Health Care Service Delivery to Refugee Children from the Democratic Republic of Congo Living in Durban, South Africa: A Care Giver's Perspective

Submitted in Fulfilment of the Requirements for the Degree Master of Social Science (Health Promotion) in the Discipline of Psychology, School of Applied Human Sciences, University of KwaZulu-Natal, Durban, South Africa

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DECLARATION

This is to certify that I have prepared this dissertation report entitled “health care service delivery to refugee children from the democratic republic of Congo living in Durban, South Africa: a care giver’s perspective” This dissertation is my own work and all primary and secondary sources have been acknowledged. This dissertation has not been submitted before for any other degree in any other university. This dissertation is prepared in fulfilment of the requirement for the degree Master of Social Science (Health Promotion) in the Discipline of Psychology, School of Applied Human Sciences, University of KwaZulu-Natal, Durban, South Africa

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March 2016

This dissertation has been read and was approved for submission

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DEDICATION

This work is dedicated to the creator Lord for his unconditional love, to my family, for their support and encouragement, and to Prof Anna Meyer-Weitz not only for the supervision but also for her support and encouragement without her; this work would not have been done

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For I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in, I needed clothes and you clothed me, I was sick and you looked after me, I was in prison and you came and visited me."

Matthew 25 vs. 35

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ABBREVIATIONS

AIDS: Acquired Immune Deficiency Syndrome

ART: Anti-retroviral treatment

BCG: Bacilli Calmete-Guerin (Anti-tuberculosis vaccine)

CASE: Community Agency for Social Enquiry

DMC: Divine Mission Church

DoH: Department of Health

DRC: Democratic Republic of Congo

DTP-IPV/Hib: Diphtheria, tetanus, pertussis vaccine, inactivated polio vaccine, Haemophilus influenza type b vaccine

EPI: Expanded Program of Immunisation

IoM: Institute of Medicine

MDGS: Millennium Development Goals

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RSS: refugee social services

RV: Rotavirus vaccine

SPSS: statistics package for Social Sciences

TB: Tuberculosis

Td: Tetanus and diphtheria vaccine

TOPV: Trivalent oral polio vaccine

TT: tetanus-toxoid

U5MR: Under-five mortality rate

UNESCO: United Nations Educational, Scientific, and Cultural Organization

UNHCR: United Nations High Commissioner for Refugees

UNICEF: According to the United Nations International Children's Emergency Fund

WFP: World Food Programme

SP: Social protection

DEFINITION OF CONCEPTS

Refugees The United Nations High Commissioner for Refugees website (UNHCR 2004), defined a refugee: as an individual who, "owing to a well-founded fear for causes of race, religion, nationality, attachment to a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country" (The 1951 Convention relating to the Status of Refugees, pp.55).

Asylum seekers: Asylum seekers and refugees are similar as asylum seekers also fit the definition given to a refugee. The exception is that they asylum seekers are without status. The South Africa Department of Home Affairs (2010) states that asylum seekers are issued with a temporary permit according to Section 22 of the refugee act No.130 of 1998.This is however different from refugee status (Section 24 of the refugee act No.130 of 1998).

Refugee Children: When parents/caregivers seek safety outside of their country of origin, their children automatically become refugees. They may also become refugees by being born from parents who are already refugees (WHO, 1996)

Health: Health according to the World Health Organization (WHO) is a state of complete physical, mental and social wellbeing and not only the absence of disease or susceptibility to disease. Therefore health is holistic and links all the factors that determine human well-being, including the physical and social environments that are conducive to good health.

Access is the ability to enter a place without any discrimination or limits on the basis of where you live, gender, age or race (McIntyre et al., 2009). This also refer to health care

access and meeting of patient's need (Mclntyre et al., 2009). In this study 'access' is defined in terms of three dimensions of care namely, affordability, availability (i.e. healthcare facilities), and acceptability of healthcare services. According to the WHO, it is crucial that healthcare meet all the above mentioned requirements in order to respond to the needs of clients (Penchansky, 1977).

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ABSTRACT

Background: Access to health care for refugees remains a challenge because of the various personal and health system obstacles they may face i.e. language barriers, poverty, negative attitudes of health care providers and their lack of understanding of the legal status of refugees in South Africa. Psycho-social and economic factors impact negatively on refugees' general health status including their children (new born and young children). Children's health vulnerability includes preventable and treatable conditions such as malnutrition and infectious diseases, and conditions related to their experiences of threat to safety, violence and accompanied uncertainties followed fleeing to and settling in the new host country. These children have a greater health and wellbeing vulnerability than the average child. Little information is available about the challenges that refugee care-givers experience regarding child health care services in South Africa.

Objectives: The main aim of this study was to investigate refugee caregivers' perceptions of their children's health care problems and challenges regarding accessibility and quality of health service delivery to their young children.

Methods: This study used an explanatory mixed method design in which a quantitative cross-sectional survey was followed with a small qualitative study to enable a deeper understanding of the quantitative responses. The approach therefore allowed for the examination of the prevalence of health problems reported by caregivers, and exploration of

caregiver's experiences when seeking health care for their children. The research instrument assessed some background information i.e. socio-demographic characteristics, sources of social support and perceived health status of refugee children and perceptions and experiences with health care services. Frequencies were calculated, Chi-square ($\chi 2$) test were used to explore the factors associated with refugees' satisfaction of health care provided as well as non-parametric tests i.e. Mann-Whitney U Tests and Kruskal-Wallis tests to assess the median scores on the satisfaction with health care clinics and private doctors measures for different demographic groups i.e. gender, level of education and English proficiency as well as household resources. Thematic analysis were used for the open ended questions

Results: The majority (89%) of the caregivers were women with over 70% of them between 30-35 years. The majority (80%) of the caregivers were married, 65% of them had 3 to 4 children and over two-thirds (74%) reported to have problems in communicating in English. Most caregivers (74%) visit public clinics for their children's health care needs because it was free of charge (79%) as they were not able to afford private health care (17%). However, over 95% of the participants revealed that most of the health care workers were not receptive of refugees, making access to health care difficult. Satisfaction of health care service delivery was very poor as only 7% indicated to be somewhat satisfied. Despite demographic group differences the caregivers' level of satisfaction were very similar across the different groups. Caregivers with no English language proficiency reported slightly more positive attitudes towards clinic health care services.

Conclusion: The refugees seemed to have very limited household resources making general daily survival challenging. Their strong social networks and cohesion enable them to cope, but also seem to reinforce negative views about public health care service delivery. The existing xenophobia in the South African society play a role in negative perceptions regarding access to health care and their experiences of health care service delivery. Health care workers need to be made aware of their responsibility to deliver quality care not only South Africans alone, but to refugees as well. Refugee caregiver's should be made aware that many complaints directed at health care workers might be system related and not necessarily addressed at refugees. Greater efforts should be made to foster mutual respect and greater integration.

Key words: Refugee children, satisfaction, health care services, accessibility, care providers

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

From all over in the world, the mass movement of people is often a result of political and economic instability, poverty and armed conflict. Critical conditions as these push people out of their home countries in search of greater stability and refuge in other countries believed to offer a better place to live (UNHCR, 2015). Africa has become a land of major conflicts and instability resulting in many seeking protection in developed countries such as Europe, America, and in other more stable African countries like South African. The mass relocation of people can cause huge challenges to public resources during their movement and in the various countries of destination. Most countries in Africa, who agree to receive refugees, are faced with challenges to address the needs of their own people as well as that of refugees entering their countries (Apalata, Kibiribiri, Knight, & Lutge, 2007).

Refugees can be defined as "people who have left their usual place of residence and crossed an international border because of persecution (based on race, religion, nationality, political opinion, and membership in a particular social group), armed conflict or violence", and owing to these reasons are unwilling to return to their country of origin" (Pavlish, 2007, p. 28).When the Office of the United Nations High Commissioner for Refugees (UNHCR) was established in 1951, there were approximately 1.5 million refugees internationally (McMaster 2001). At the end of 2010 there were about 43.7 million displaced people worldwide, including 15.4 million refugees, 837 500 asylum seekers and 27.5 million internally displaced persons (IDPs) (UNHCR, 2010). There are about 9.8 million refugees in Africa (Pavlish, 2007). As the end of 2010, approximately 7.2 million refugees have remained in this state for prolonged periods of time, the highest figure since 2001(UNHCR,

2010). The current wave of refugees in the Middle East is fuelled by war, conflict and persecutions where 42,500 people per day abandon their place of living. To date Syria is the country with the largest number of refugees in the world since 2014, with 95% of people being displaced (UNHCR, 2015) resulting in many seeking refugees in nearby Turkey and European countries.

Within Sub-Saharan Africa, South Africa has been the destination for most refugees from other Sub-Saharan countries because of its agreement with the United Nations High Commissioner for Refugees (UNHCR) in 1993 to manage refuge-related issues.As a result of this agreement, South Africa is hosting a number of refugees from others Sub-Sahara African countries. In 2010 there were approximately 270, 671 refugees and asylum seekers, most from the Great Lakes region of Africa, namely the Democratic Republic of the Congo, Burundi, Rwanda, and Somalia (Refugees Social Services, 2010). The war in these regions has resulted in forced displacement of thousands of people, of which many are children (Insight on Conflict, 2010). In the Democratic Republic of Congo (DRC) it was estimated that about 2.8 million people were internally displaced and many sought refuge in neighbouring countries including South Africa. The continuation of political instability over the last years has contributed to the 1 million of people being internally displaced at the end of 2014 (UNHCR 2014). However, about 561,000 people have returned to the DRC (UNHCR 2014).

1.2 Rationale of the study/Problem statement

The complex interactions between refugee status and health show that it may either have adverse or positive impacts on health and well-being. A compromised health status and access to adequate health care are two major areas of vulnerability that refugees face.

Maintaining good health is a challenge because of poverty and the undesirable conditions in which many forced migrants live and the health risks commonly associated with the movement of people (Landau, 2007).

While refugees in general are considered being a vulnerable group, refugee children (new born and young children) are particularly vulnerable. Infants and young children are often the first and most frequent victims of violence, disease and malnutrition, infectious diseases which accompany population displacement and refugee movements (Rieder & Choonara, 2012). Many of such conditions can however be effectively prevented or treated (WHO, 2015). These children face far greater dangers to their safety and wellbeing than the average child as a result of the sudden and violent onset of emergencies and related uncertainties (Burns, et al., 2000; WHO, 2015).

It should be noted that children under five years in general, have a very high rate of mortality. According to the latest worldwide mortality estimates, the WHO (2015) reported that more than 5.9 million children died in 2015. While this is still a very high rate, the figures also show about 19 000 fewer children died every day in 2015 than in 1990, the baseline year for measuring progress(WHO, 2015). This reduction has been attributed to improved child survival interventions, such as immunization, nutrition control, and treatment of childhood diseases. However, most gains in child survival rates seem to be a result of the declines in post-neonatal mortality. In many developing countries the reduction

of child mortality remains a challenge, especially neonatal mortality, which in 2008 accounted for 41% of under-five deaths (WHO, 2011).Maintaining good health among refugees is a challenge not only because of the health risks commonly associated with the movement of people but also because of economic hardships refugees face and the undesirable conditions in which many refugees function (Beirens, Hughes, Hek, & Spicer, 2007). It is therefore critical for refugee children to access the host country's local primary health care services (Beirens et al., 2007).

Social and economic networks are important for refugees, not only in selecting a country of destination but also in the host countries to survive, to gain access to information and services including health care services. These networks can be understood as "communities of support" which provide both monetary assistance and knowledge, and encouragement to overcome difficulties including ill health. One reason given for the establishment of strong networks is to help other refugees who would otherwise be destitute, find a place to stay when they arrive and to deal with different challenges including the utilization of health care services. In addition, these social networks are also likely to facilitate integration after arrival in the sense that social networks may provide newcomers with information about health care issues, accommodation, some income and jobs (Monche, 2007; Ryan, Sales, Tilki & Siara, 2008). Social network analysis has emphasized the importance of interpersonal networks that link people in ways that allow them to cope with everyday life

and extraordinary circumstances and to link them with others who may be of use (Amisi, 2006).

Congolese refugees living and working in Durban would therefore be inclined to utilize elements of social capital, common language, nationality, tribal lineage, as tools to facilitate their economic survival.

Evidence indicates that individuals relied heavily on informal social support from friends and family, and that this strongly influenced help-seeking including health care seeking (Simao & Nhambi, 2008). Advice is often sought from friends, family and the community pharmacy before seeking help from health care services. However, inadequate access to health care services by refugees and their general low levels of satisfaction with these services seems partly linked to services that are not responsive to their needs (Apalata et al., 2007).

Against this background and the lack of research studies regarding refugee children's health care access, this study will therefore aim to contribute to a better understanding of parents and caregivers' perceptions of the health care needs of refugee children (ten years and younger) as well as their perceived access to primary health care including their satisfaction with health care services for their children.The study will focus on the parents and caregivers of refugees from the DRC by using an explanatory mixed method design in which a cross sectional survey will be followed by a small qualitative study.It is hopeful that this

information could be used to inform the International Organization for Migration (IOM), an intergovernmental organization dedicated to promoting humane and orderly migration and forced migration worldwide by serving the policy and programme needs of governments and migrants worldwide, and the National Department of Health about the key health challenges that parents/caregivers of children face.

1.3 Aim and Objectives

The main aim of this study was to investigate refugee parents/care givers' perceptions regarding health service delivery to their young children. In relation to this aim the study has the following objectives:

- To determine the specific health care problems that refugee children experience and to investigate caregivers perceived accessibility of health care services in Durban, South Africa.
- To investigate the caregivers satisfaction with health care services provided to their children by public clinics and private doctors in Durban, KwaZulu-Natal.
- To qualitatively explore caregiver's perceptions about health care service delivery to their childrento better understand the quantitative findings of the study.

1.4 Research Questions

In lieu of the objectives, the study strived to provide answers to the following research questions which are presented below:

- What health care problems do refugee children living in Durban, KwaZulu-Natal experience?
- How do caregivers of refugee children access health care services in Durban, South Africa?
- Are caregivers of satisfied with health care services provided to their children by public clinics and private doctors in Durban, KwaZulu-Natal?
- What are the experiences of caregiver's about health care service delivery to their children in Durban, KwaZulu-Natal?

1.5 Outline of the dissertation

Chapter one – Introduction

The section above addressed the background to the study, aim and objectives, rationale as well as the main research questions of the study. The general outline of the dissertation is presented here under:

Chapter two – Literature Review and theoretical frame work

This chapter represented an overview of the relevant literaturefocusing on refugee socio economic status, social networks, refugee's children healthcare issues, quality of healthcare services provided to refugee children level of satisfaction with the health care services in general and specifically during the consultation process. Lastly the theoretical frame works of the study is explained.

Chapter three – Research Methodology

In chapter three, the research methodology that includes; research paradigm and design, sampling method, research instrument and the ethical considerations in data collection, as well as the data collection procedures and the methods of data analysis which include the quantitative statistical tests and qualitative data analysis.

Chapter four – Results

In this chapter all results from all statistical analysis utilized in this study are presented. Research results are provided in different sections: In the first section the socio-demographic characteristics of the participants is presented. In the second section, the socio-economic status and available social networks of the participants are presented.Section three,the medical history and general health care seeking is presented followed by section four in which the level of satisfaction and consultation experiences withpublic and private (doctor) healthcare services are shown.

Chapter five – Discussion and conclusion

In the fifth chapter the discussion of the findings is presented aligned to the research objectives. The findings of the study are discussed in relation to the literature and the theoretical frame work followed by the conclusions and recommendations.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter provides an overview of the literature regarding refugees' healthcare needs, utilisation of healthcare services and access to health care. Barriers to health care services such as socio-economic status of refugees, language, cultural practices and beliefs and attitudes of health care workers will be addressed. This review will focus primarily on the South-to-South refugee movement and not the predominant focus of refugees migrating from the South to the North. This chapter will conclude with a discussion of the theoretical framework adopted for the study. The study was informed by the conceptual framework for health service access as outlined by Peters, Garg, Bloom, Walker, Brieger and Rahman (2008), the Household Resource Model of Wallman and Baker (1996) and the Social Network and Economics theory of Barnes (1954; cited in Lomnitz, 1977). These theoretical frameworks informed the study and provided the study a lens through which the findings were interpreted.

2.2 Health and Wellbeing Vulnerability refugees

The unprecedented increase of refugees due to violent conflict in different parts of the world is a major cause of concern UNHCR (2013). Refugees are generally viewed as those who are forced to leave their country of origin for another because of armed conflict, violence, persecution and threats to their physical and emotional safety based on aspects such as their nationality, race, ethnicity, religion, political views or membership to social groups viewed as undesirable, armed conflict and violence (Smit, 2015).

South Africa has been the destination for most refugees from other Sub-Saharan African countries because due to its agreement with the United Nations High Commissioner for Refugees (UNHCR, 2014) in 1993 to manage refuge-related issues. Because of this agreement, South Africa is hosting a number of refugees from others Sub-Sahara African countries. In 2010 there were approximately 270,671 refugees and asylum seekers, most from Eastern and Central African countries including the Democratic Republic of the Congo (DRC), Burundi, Rwanda, and Somalia (Refugees Social Services, 2010). The war in this region has resulted in forced displacement of thousands of people, of which many are children (Insight on Conflict, 2010)

Refugees are considered to be a vulnerable group partly due to their physical and mental health status combined with infrequent and interrupted access to adequate healthcare services including contexts of poverty (Kirmayer, Whitley, & Fauras, 2009). According to the WHO (2010) refugees, particularly those from war torn countries, may face various critical physical and mental health conditions requiring more urgent specialised care. However, the most vulnerable in these conditions are the sick, elderly, those living with disability and children. Infants and young children are often the first and most vulnerable casualtiesof displacement, violence, emergencies and the accompanied uncertainties that occur in these contexts (Schauer, 2008). Refugee children face far greater dangers to their safety and well-being through trauma, disease and malnutrition than most other children (Schauer, 2008). Many countries subject refugees to a comprehensive health assessment after they have settled in the host country to improve their physical and mental health outcomes and to identify the need for ongoing monitoring of refugee health and wellbeing (Kirmayer et al., 2011).

Apart from obvious health challenges, refugees, asylum seekers and undocumented migrants face other challenges that may impact their health as they find themselves in a new environment with likely obstacles to adapt and being accepted by the local community. In addition, the difficult conditions that they may experience upon arrival in the host country, different culture and language, unemployment, lack of accommodation, difficulties related to accessing schooling, and even discrimination is likely to also impact their health (Akhema, 2009). It seems that the migration process rather than migration *per se* increase their health vulnerability (Meadows, Thurston, & Melton, 2009). While it is possible that many of these refugees' may have an improved health through access to health care when living in the new host country, this may not necessarily be the case.

It should be noted that migrants seek to create what Bolanos, Partanen, Berrocal, Alvárez, and Córdoba, (2008) call their home "healthy space" where the focus is not only on the physical, but also on the ability to be accepted and integrated in the new society as an "appropriate cultural body" (p.15). This seems to be a prominent challenge facing migrants and affecting their well-being. Therefore refugee health challenges often continue in the host country because of their compromised health status and the social and economic hardships they may face (Lasser, Himmelstein, & Woolhandler, 2008).

2.2.1. The vulnerability of refugee children

Generally, children under the age of five have a very high mortality rate (Burns et al., 2000). Child mortality according to UNICEF (2010) refers to "the probability of dying between birth and age five expressed per 1,000 live births and infant mortality rate as the probability of dying before age one expressed per 1000 live births". These indicators have widely been used as a measure for the well-being of both children's and adults (Bradshaw & Richardson, 2009). The reduction of child mortality rate, particularly those who are under the age of five

years have seem remarkable improvement over the past two and half decades (Wang et al., 2014). While more than 7.6 million children have died in 2010, these figures do only show that as compared to the mortality rate in the early 1990s, over 12,000 children's lives were saved each day (UNICEF, 2010; WHO 2010). This improvement was linked to improved coverage of child survival interventions (i.e. immunisation, nutrition, and treatment of childhood diseases). It is also important to note that most gains in child survival seem to be the result of the declines in post-neonatal mortality (UNICEF, 2013).

In Sub-Saharan Africa, child mortality has increased over the last 30 years. In 2010, a WHO report estimates that roughly 6 million of those deaths could have been easily averted through immunization or treatment as they are due to malnutrition, acute respiratory infections, diarrhoea, malaria, or measles (WHO, 2010). An earlier study conducted in DRC reported that as many as 300, 000 children in the early 1990s reportedly die yearly from immunisable diseases, as well as malnutrition, malaria and diarrhoea (Wang et al., 2014). It should be noted that the DRC, the country of origin of the study participants, has the second highest child mortality rate followed by Nigeria since the year 2000 (Wang et al., 2014). Preventive health care might not be generally available to refugee children. It is therefore critical for refugee children to have appropriate and accessible primary healthcare services in their new host countries (WHO, 2015). It is therefore important that refugee children from the DRC be given special attention when arriving in South Africa.

2.2.1.1 Child immunisation as health promotion action

Immunisation is defined as a means of protection for people against infectious diseases. This is done by using the body's natural defence mechanism to build resistance to specific infections. The Expanded Program of Immunisation (EPI) which was initiated to help

decrease both morbidity and mortality have helped in Africa (Khasakhala, Agwanda, Kimani, & K'Oyugi, 2011). This initiative according to researchers is one of the most effective yet low-cost, high-impact public health initiative likely to save millions of lives yearly should programmes be effectively implemented by governments with the required resources and support (Jamison, Murray, Lopez, & Ezzati, 2006). Six diseases remain a major priority for the WHO, namely, tuberculosis, diphtheria, tetanus, pertussis, poliomyelitis (polio), and measles. In 1988 the WHO recommended the addition of the yellow fever vaccination.

While most infectious diseases have been eradicated in South Africa, there should however be concern for refugee children as most of them come from poor war-torn countries with fragmented health care services and poor infrastructure (e.g. transport) resulting in poor public health coverage and there inaccessibility to services. In a study conducted in the DRC during 2008 to determine the reasons for having the lowest coverage of immunisation in Africa, the report highlighted that in 1995 the routine coverage was as low as 47% for tuberculosis (BCG), 27% for diphtheria, pertussis and tetanus (DPT3), 28% for polio (OPV3) and 39% for measles vaccinations (Mapatano, Kayembe, Piripiri, & Nyandwe, 2008). This low coverage was partly due to an absence of a budget allocation for the healthcare system by the administration of the country (Mapatano et al., 2008). Good health systems and a supportive health administration are needed to ensure successful vaccination coverage while caregivers need to be knowledgeable and well informed of the need for these services (Mapatano et al., 2008).

In South Africa, the Expanded Programme on Immunization (EPI-SA) was introduced in 1995 covering six diseases. To help access, additional vaccines have become available worldwide and several of these are likely to impact on the burden of vaccine-preventable

diseases in South Africa. The introduction of combination of these vaccines as well as enhancing improved vaccines which may have contributed to the success of the programme (Department of Health, 2004). Immunization schedules for developing countries have also been adapted to suit the epidemiology of the diseases in their countries (Department of Health, 2012).

Enhancing adequate immunisation coverage to substantially reduce infant and child mortality are high priority national public health objectives in South Africa (Department of Health, 2012). The South African health system provides full child immunization from birth till 12 years where after they are given a second dose of immunisation. This differs from the vaccination programme in the DRC as depicted in the DRC immunisation form (See Appendix 5). For the DRC, the vaccination schedule ends at 5 years of age where the South African schedule includes children up to 12 years (for booster immunisations). This big difference is explained by the poor healthcare program in the DRC, where the budget allocated to address healthcare issues are limited and in most case are not reaching the destination (Mapatano et al., 2008). Brief overview will be given below of the key conditions that children should be immunised against.

Polio

Polio infection is caused by a virus called poliovirus. This infection is characterized by various symptoms such as headache drowsiness, fever, nausea, malaise, vomiting, oesophagus pain and constipation (Jamison et al., 2006). Polio infection is mostly transmitted by the faecal-oral route. The infection of Polio is more frequent in unhygienic living conditions.

Measles

Measles was noted as the highest infectious disease among all diseases and is transmitted from one person to anther though droplets from coughing or sneezing (Griffin & Oldstone, 2008). With the exception of isolated communities, through contamination, this disease may spread to the whole community in the absence of measles immunization. This infection is mainly prevented in children born by immune mothers, if the vaccination is administered within the first six months of the child's life. Measles infection is characterized by several symptoms such as fever, rhinorrhoea, coughing and conjunctivitis. This is accompanied by a rash which appears within the first four days after onset. Some notable complications associated with measles according to researchers include blindness, encephalitis, pneumonia and diarrhoea (Russell & Peng, 2009).

The vaccination for measles is usually done with the combination with rubella vaccine, or sometimes a combination with mumps and rubella vaccines and is also available as a self-administered patch. Approximately 95% of children vaccinated with at least one combination of the vaccine develop immunity. However, individuals who are not able develop immunity with one dose are more likely to do so upon receiving a second dose (Jamison et al., 2006).

Diphtheria-Tetanus-Pertussis

According to (Jamison et al. 2006)**,** these three diseases are usually associated when a common vaccine is administered for eradication or for control. The discussions of these diseases are presented below.

Diphtheria:

Diphtheria is caused by toxin-producing strains of the bacterium called Corynebacterium diphtheria. This bacterium can be transmitted from one person to other person through

respiratory droplets. The bacterium affects several areas including the pharynx, tonsils, inner ear, skin or even the virginal. Respiratory diphtheria may also cause a sore throat with an accompanying mild fever. Myocarditis and neuritis are two other complications associated with respiratory diphtheria. Cutaneous diphtheria presents as skin lesions and causes far fewer complications and deaths among those infected. The EPI traditionally recommended a combination of three doses of diphtheria-tetanus-pertussis (DTP) vaccine particularly in the first year of a child's life in addition with the polio vaccine. The risk of diphtheria widespread is common within communities which have an adult population with compromised immunity (Jamison et al., 2006).

Pertussis

Pertussis also calledwhooping cough is a transmissible disease triggered by the bacterium Bordetella pertussis, and is spread through respiratory excretions- characterised by contractions of coughing followed by inspiratory screaming. These spasms can vary in measurement and sternness, but may also become severe particularly in infants, where respiration is compromised; resulting in hypoxia (is a condition where the tissues are not oxygenated adequately, usually due to an insufficient concentration of oxygen in the blood). In some extreme cases this can cause neurological damage (Wendelboe et al., 2007). As at 2010 an estimated 20-40 million cases of pertussis were recorded per year and about 200,000– 400,000 deaths were attributed to pertussis, with 9 out of 10 of these deaths occurring in developing and underdeveloped countries (WHO, 2010). To improve diagnostics for this disease a need for trained physicians is a more reliable tool of prevention (Centers for Disease Control (CDC), 2011). This disease in characterised by a cough that continues for at least 14 days. These symptoms are vital when considering a diagnosis of pertussis in remote areas where there are lack of adequate medical services and professionals (Patriarca, 2012).

Tetanus

According to the EPI program this infection is known as the only infection which can be preventable through vaccination, this disease is also known as a no communicable disease which is transmitted through environmental pollution. This infection grows in a dirty flesh wound through the bacterium clostridium tetanic. When this infection is not correctly treated it can progress within the human resulting in a number of deaths and desolation. This infection is more frequently observed in the developing countries and mostly the infection is due to contamination of unsterile instruments, especially during the delivery of a baby. In most cases contamination of this disease is caused when the umbilical cord is cut using unsterilized instruments (Alparslan & Demirel, 2013). Mostly this infection appears within the first 3-14 days after birth, succeeding a period of normal feeding. Infants affected with tetanus disease can be identified as a child who gradually loses the capability to nurse properly and then followed by a period of convulsions, which increase in strength and occurrence (Alparslan & Demirel, 2013). A double vaccination for prevention through immunization is tetanus-toxoid (TT). This disease is mostly prevented by immunizing the pregnant mother during her vaccination program with tetanus-toxoid; this vaccination may be either during pregnancy or outside of pregnancy

Tuberculosis

Tuberculosis (TB) is a bacterial infection caused by Mycobacterium tuberculosis, transmitted though respiratory droplets and extremely contagious. According to Cuevas et al. (2012), TB contamination is more frequent among people who live in close proximity to someone who is contaminated with this disease with an infection rate of 25 to 50% for these individuals. This disease is known from several symptoms which are mostly clinical. The symptoms depend on age. The most TB symptoms are night sweats, loss of appetite, weight-

loss, coughing, malaise, irritability, and fatigue. This disease can also cause meningitis in infants or with chronic infection.

As prevention, the bacilli Calmette-Guerin (BCG) vaccination was set to attenuate the bacteria. The vaccine is normally administered intradermal at birth to prevent tuberculosis. Living in insalubrious conditions can cause the contraction of TB. Worldwide, this disease causes 2 to 3 million deaths per year and probably infects 8 million people (WHO, 2009). Most of these deaths and infections are located in Sub-Saharan Africa. Since 2005, the prevalence of tuberculosis has increased in South Africa with an estimated number of cases of 250000 a year (558 cases per 100 000 population per year) (Harling, Ehrlich & Myer, 2008). Tuberculosis is a common opportunistic infection of HIV and accounts for the increase in prevalence (Cuevas et al., 2012)

Yellow fever

In 1988 the WHO recommended the addition of the yellow fever vaccine to the national immunization program in countries that are at risk for such disease (Staples, Gershman, & Fischer, 2010). Yellow fever is known to be an acute viral infection transmitted by mosquito bites, mostly through the Aides Aegyptus. The symptoms associated with yellow fever infection vary, thus making diagnosis difficult, and possibly underestimating its ability to cause death (Stapleset al., 2010). The DRC is among the 33 countries where this infection is a high risk. According to the WHO (2010), the DRC has a mortality rate of 2·1 deaths per 1000 per month (95% CI 1·6–2·6). This was 40% higher than in what exist in other countries within Saharan regional.

HIV and AIDS

An estimated 125 million pregnant women in low and middle-income countries, an estimated 1.4 million were living with human immunodeficiency virus (HIV) infection

(WHO, 2010). In a study done in Uganda, the result shows the importance of HIV testing as a major prevention strategy of HIV for infants born by mothers who are HIV positive as about 25–45% of births from HIV-positive mothers during pregnancy, delivery and/or breastfeeding in developing countries would be infected when this in not widely implemented to ensure adequate treatment of mothers and infants (Auvinen, Kylmä, Välimäki, Bweupe, & Suominen, 2014). The efficacy of antiretroviral (ARV) drugs has been documented (Chigwedere, Seage, Lee, Essex, 2008; Horvath et al., 2010). Approximately 53% of 1.4 million pregnant women in low- and middle-income countries received antiretroviral treatment (ART) to reduce the risk of mother-to-child transmission (MTCT) of HIV (Auvinen et al., 2014).

Approximately 1500 children become infected daily throughout the world with HIV (UNAIDS 2013). More than 90 % of children living with HIV have been infected through mother-to-child transmission (MTCT) (Falnes, Tylleskär de Paoli Manongi, 2010; Reecea, Nangamic, Laned, 2010). Most of these infections occur largely in Sub-Saharan Africa (Eide et al., 2008). HIV can be prevented by available interventions, such as HIV testing, and early treatment of pregnant HIV infected mothers, from as early as 14 weeks of gestation - second trimester (WHO 2010). In addition, the management of the labour process, informed decisions on breast feeding, and paediatric care are all important interventions when preventing PMTCT (Barigye et al., 2010; Babiker, Mohammed, Herieka 2010).

In the DRC, a review conducted in 2010 estimated that out of all new HIV infection cases, 59 % occurred in women of reproductive age (15–49 years). PMTCT services are therefore a high priority. Effective delivery of PMTCT services is highly rewarding, as it can reduce the risk of MTCT of HIV infection and ultimately eliminate new HIV cases among children. It should be noted that migration increase the risk for the spread of HIV (Lurie et al., 2003).

The vulnerability of refugees for HIV/AIDS infection is significant (Jochelson et al., 1991; Lurie, 2000) but particularly so for refugee mothers from the DRC against the infection rate in the DRC, noted above.

2.2.1.2 Other health conditions

Malnutrition is defined as " lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one should eat, or eating unsuitable food as well as being over nourished" (Polonsky, Ronsse, Ciglenecki, Rull & Porten, 2013, p 2.). Malnutrition is more noticeable in regions of instability where people are forced to move from one place to another daily due to armed conflict (Jemal & Haidar, 2014).

Refugee nutrition issues are shared by the United Nations High Commission of Refugees (UNHCR) and the World Food Programme (WFP). The responsibilities of these organisations are among others to meet refugee nutritional and well-being needs (UNHCR, 2008). The United National High Commission of Refugees (UNHCR) annual report indicated at the end of 2014, an estimated 59.5 million people were forcibly displaced worldwide (UNHCR, 2015). The breakdown of this shows that 19.5 million of the people were refugees; an increase of about 2.9 million people from the previous year. About 38.2 million of the people were classified as internally displaced people (IDPs). More than half of the total of refugees and displaced people across the world were malnourished (WHO, 2015). Malnutrition is more visible in most places where people don't have access to food (i.e. in the refugee camps or in places where people don't have access to healthcare education (Bain et al., 2014).

Malnutrition is particularly visible among children due to their dependency on their parents or caregivers, and their susceptibility to various diseases. Children may be at risk of

malnutrition if they are not breastfed adequately (WHO, 2010). Furthermore, children with low nutrition levels face a higher risk of disease infection including, tuberculosis, malaria measles and pneumonia, and can negatively influence both physical and mental development (Thaxton, 2004; WHO, 2010). According to the WHO "many children with severe malnutrition experience life-threatening complications, including infections, hypothermia, hypo-glycemia or dehydration" (WHO (2010). The reported further indicated that whether a refugee child has been exposed to a short-term emergency situation or a protracted refugee situation, there will be an impact in both extent and form of malnutrition.

Acute respiratory infections among refugee children

According the World Health Organization Report in 2010 (WHO, 2010), a high number of children under five years (20%) were affected and had been hospitalised due to acute respiratory infections of which 90% of these cases were a result of pneumonia. This also accounts for the about 1.9 to 2.2 million childhood deaths per year in the world (WHO, 2010). African countries in particular have very high rates of infection (Jamison et al., 2006). In a study conducted in Zambia on influenza and its related illnesses, the researchers found out that children under the age of five were the most affected by respiratory infections (Theo, Liwewe, Ndumba & Monze, 2008),.

Diarrhoea among refugee children

The acute gastroenteritis is among the most important causes of child mortality and hospitalization worldwide. It has been reported that from the total of 10.6 million under five years mortality worldwide, about 42% of these death occur in sub-Saharan Africa (Lamberti et al., 2014). Child mortality and morbidity worldwide due to diarrheal diseases are very high, and there are as many as 1.5 to 2.5 million deaths of children under the age of 5 years

annually (Quattrochi, Jasseh, Mackenzie, & Castro, 2015). The morbidity and mortality rate due to diarrhoea worldwide has also led to widespread campaigns especially in developing countries to eradicate diarrhoea with the use of oral rehydration therapy (ORT) (Santosham, Keenan, Tulloch & Glass, 2010). The development of ORT was as a result of successful collaboration between basic and applied biomedical research. While initially development were directed at developing countries, this has now become standard of care worldwide (Santosham et al., 2010).

Malaria

Malaria remains a major problem and cause of death in the African region with an alarming increase in the past few years rate (WHO 2010a). An estimated 500 million cases due to malaria are reported with 1.5-2.7 million deaths, over 90% of these are children less than five years of age in Africa (WHO, 2010b). In Africa, malaria is considered to be third disease to have caused more death just behind acute respiratory infections (3.5%) and tuberculosis (2.8%) (WHO, 2010b). Malaria cases reported in Africa accounts for approximately 90% of global cases (WHO, 2010b).

2.3 Health care service utilisation

Research suggested that forced migrants have a tendency not to seek healthcare from public healthcare services due to the confusion with new health care systems and also inappropriate healthcare delivered to foreigners at public facilities (Dunlop, Coyte & McIsaac, 2010). In order to understand the utilisation of health care services, it is important to understand some key aspects linked to health care seeking namely availability, acceptability and quality.

With regards to **availability,** this refers to maintaining good quality of healthcare service. "This should include fundamental determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs" (WHO, 2012, p. 2). Accessibility, defined as an affiliation between the client and the place of interested or place where the needs are delivered, taking in consideration the clients transport availability, distance from home to the point and cost where is applicable (Gulliford, 2002). In the case of refugees it might be argued that accessibility include the use of interpreters to assist in the health care facilities dealing with refugees who are not English speaking (WHO, 2012).

Acceptability refers to healthcare facilities and service delivery quality. Service delivery is to be respectful with consideration of human rights, medical ethics and be culturally appropriate to the people. It must also be sensitive to gender, appropriate to life-cycle of the individual and designed to assure confidentiality and ultimately improve the health status of the citizenry (UNHCR, 2010). Quality issues also refer to the requirement for health care workers to be skilled and to apply best practices in the management and treatment of clients and patients. Drugs that are to be used should be scientifically approved and be appropriated for the treatment of the diagnosed condition, that facilities should be safe and that the highest standard of infection control should be practiced including safe water and sanitation (Have, Vollebergh, Bijl & de Graaf, 2011). Knowledge of illnesses and diseases common in the countries refugees came from will be linked to the quality of services offered to refugees as the presentation of symptoms of unknown diseases may negatively impact on diagnosis and therefore the treatment process (Lindert, Schouler-Ocak, Heinz & Priebe, 2008).

There seems to be limited literature that looks at the strategies employed by forced migrants when they are unable to access formal healthcare. The literature that examines the alternatives to formal healthcare services concentrates extensively on African indigenous healing systems and popular medicine. Some researchers such (e.g. Feierman, 2009; Kleinman, 2008) have highlights the social determinants of health within the broader environment, a very useful approach when studying refugees whose social exchange has been characterised by unpredictable and often violent processes. In addition, 'patterns of control'implying power dynamics exist within the health system and impact the interaction process between refugees and health care workers e.g. doctors and nurses. It has also been argued that it is exactly this "authority" that can significantly impact the interaction process between migrants and health workers (Tjale & De Villiers, 2007). The host country's lack of understanding of refugees' problems and cultural values may have negative outcomes on provision of healthcare and could create obstacles in delivering effective healthcare and establishing mutual trust between healthcare providers and refugees in especially primary healthcare settings (Uiters, Deville, Foet, & Groenewegen, 2010).

Furthermore, accessibility and acceptability of healthcare services can be constrained by different barriers as outlined below.

2.4 Barriers to Access health services by refugees

Different barriers may impede the accessibility of health care services to refugees. A lack of knowledge regarding the Refugees Act (130 of 1998) granting asylum seekers and refugees access to various social and health care services similar to that entitled by South African citizens is considered to impede refugee access to health care services. The low socio-economic status of refugees, language differences and different cultural beliefs and practices

(Dyck & Dossa, 2007) as well as health worker attitudes towards migrants or refugees impact health care service access and clients' levels of satisfaction with health care delivery.

2.4.1 Human and legal rights of refugees

A 1998 survey conducted among South Africans by the Community Agency for Social Enquiry (CASE) suggests that negative attitudes towards forced migrants may be a part of a broader problem of human rights awareness. Lack of awareness among facility staff and medical professionals about rights guaranteed in the Constitution and the Refugees Act (130 of 1998) has contributed to the confusion which exists about the different categories of refugee groups and how they are defined under the South African Law.

Part of the lack of knowledge about refugee rights could be due to a lack of familiarity with the various documents, show that 20% Congolese living in South Africa are recognised refugees, yet only 1.4% of them had a legalised identity document (Crush& McDonald, 2000). Without this document, it is difficult for refugees to demonstrate that they are recognised refugees and eligible to claim the rights they are entitled to in terms of the above mentioned Refugees Act. Lack of knowledge concerning the different identification documents may impact negatively on health service delivery. It is such documents which distinguish refugees and asylum seekers from foreign migrants who are required to pay money to receive healthcare.

2.4.2. Socio-economic status of refugees

Refugee and asylum seekers' socio-economic status is one of the potential barriers in accessing basic services in general but particularly health and support services in the host country (Swartz, 2009). This is further enhanced by their lack of understanding of the new

country's health care system and costs involved. Access to healthcare services cannot be considered within economic terms only as it linked to the political, legal and social difficulties experienced by refuges (Swartz, 2009). Refugees and asylum seekers are likely to leave their communities and homes unwillingly and to come from poor economic environments due to conditions of war or civil strife (Crisp, 2010). The lack of money to pay for healthcare services including treatment is a major barrier in a country with economically vulnerable groups such as refugees and the poor local population (Ramsden & Marsh, 2014). A positive association exists between higher levels of socio-economic status and the improved accessibility to healthcare services that impact on the standard of health and wellbeing in a community (Becker, Dell, Jenkins, & Sayed, 2012). Socio-economic status can be assessed through household resources that include material, social and potential investment (Wallman & Baker, 1996) as further outlined in the theoretical framework of the study.

In most instances, refugees and asylum seekers live in poor conditions which not only impact their health but also their social-wellbeing and mental health (UNHCR, 2013). A stable social economic status serves to buffer the health status of a community as this would enable them to fulfil their basics need such as food, shelter, access to healthcare, and social opportunities for upwards mobility (Lukhele, 2012).

Some researchers argue that vulnerable groups such as women and children as well as refugees and asylum seekers' health status and health care access depends on their social roles, socio-economic status, extent of social networks and stressors as well as available job opportunities (Snieska & Simkunaite, 2015).

Refugee from the Democratic Republic of Congo living in South Africa are facing huge socio-economic challenges i.e. limited job opportunities and therefore are barely able

to cover their basics needs such as food and housing (Fransen, 2015; Zihindula, Meyer-Weitz & Akintola, 2015). A study conducted by Zihindula et al. (2015), indicates that 78% of the refugee community in South Africa are unemployed due to language barriers and discrimination. The lack of English language proficiency among refugees of the DRC in particular, as they are French speaking, hampers communication which in turn impedes their full integration into the host country and ability to find suitable work opportunities (Zihindula et al., 2015). The extent of social networks among refugees has been argued to enhance their available resources to meet basic needs (Taylor, 2009). The role of social networks will be discussed in more detail in the section pertaining to the theoretical frameworks of the study. Adequate opportunities and appropriate support to refugees and asylum seekers to improve their socio-economic status is viewed as necessary for their health and well-being (Taylor, 2009).

2.4.3. Language Barriers

Global migration has contributed to the multi-cultural nature of societies (IOM, 2010). Sharing a common language assists in the adaptation or integration of migrants into the host society (Krumm, 2012). Being able to speak at least one language of the host country reduces anxiety and brings a greater sense of psychological well-being to migrants (Anbesse et al., 2009). The importance of effective interpersonal communication in the health care service delivery process is well established. When a healthcare professional and client or patient do not share a common language, various misunderstandings are likely to arise (Taylor, Nicolle & Maguire, 2013). Language barriers give rise to negative interactions between migrants and health professionals and may negatively impact effectiveness and equitability in health care delivery (Benson, Frost, Gren, & Jaggi, 2014). Effective health communication between clients and health professionals is a critical component in the

successful delivery of quality health care service in contributing to the acceptability and accessibility of health care (Jacobs, Chen, Karliner, Agger-Gupta & Mutha, 2006, Mayhew et al., 2015; Zihindula et al., 2015). Communication between health workers and patients is also important for treatment success (Mayhew et al., 2015).

It has been argued that language differences between health care provider and their patients may increase psychological distress (Meuter, Gallois, Segolowitz, Ryder & Hocking, 2015). When both patient and healthcare provider cannot speak the same language, communication efforts are required, information could be lost, inappropriate diagnosis could be made, and unwanted medication could be prescribed and treatment adherence could be compromised (Gillotti, Thompson, McNeilis, 2002; Meuter et al., 2015; Schenker, Wang, Selig, Ng, & Fernandez, 2007). In the case when of specific care is required such as trauma and stress, an incorrect diagnosis as result of a language barrier can hinder adequate treatment or result in a misunderstandings when there is a need of referral for further healthcare (Bischoff et al., 2003).

On the other hand, when the patient and healthcare worker communicate in the same language, a better health status assessment can be made (Perez-Stable, Napoles-Springer, & Miramontes, 1997); the patient is more likely to adhere to treatment and medical follow-ups are also improved (Sarver & Baker, 2000). The effectiveness of the communication process is associated with higher levels of patient satisfaction with the health care delivery process (Morales, Cunningham, Brown, Liu, & Hays, 1999). Therefore, when healthcare professionals are able to communicate with the client or patient in a common language, a higher level of healthcare delivery can be achieved.

It was found that migrants are often reluctant to seek primary health care where providers are unable to communicate in a common language (Gerrish, Chau, Sobowale &

Birks, 2004; Navuluri et al., 2014). In a study conducted by Harmsen et al. (2008), refugees felt that they are often prevented from seeing doctors and getting suitable health care treatment in public hospitals. Language differences with nurses, who act as gatekeepers to the doctors, are therefore likely to be the starting point of dissatisfaction.

A strong call for the use of professional health interpreters in the medical consultation process has been made in various studies in different parts of the world that are faced with various challenges that health care service delivery for migrants, asylum seekers and refugees bring (Bhui, et al., 2003; Burnett & Peel, 2003; Gerrish et al., 2004). While the use of formal interpreters during consultation is necessary to improve communication and understanding in arriving at the correct diagnosis and related treatment, in many contexts they are absent or not available for consultations with patients (O'Donnell et al., 2007).

In many instances where interpreters are not available, health care workers may have to rely on family members and friends, who are medically inexperienced and often have a poor command of the language shared with health care providers, to navigate the medical consultation process and argued to compromise the quality of health care outcomes for migrants and refugees (Gany et al., 2013; Gill, Beaven, Calvert & Freemantle, 2011; O'Donnell et al., 2007). In these contexts, the diagnoses, importance of adherence to medical treatment might not be clearly communicated and understood while the patient's or client's privacy and confidentiality are compromised (Gerrish et al., 2004; Hadziabdic, Heikkilä, Albin & Hjelm, 2009; O'Donnell et al., 2007). Family and friends might also be more attuned to the cultural and religious orientations of the patient and might not share all information with the client, especially when it is considered to be harmful (Giger & Davidhizar, 2008). In contexts where family and friends sanction information exchange between the patient and health care provider, the autonomy of the patient is limited and

compromise shared and informed medical decision making, valued in various countries (Hadziabdic et al., 2014). Differences in language and culture complicate communication of sensitive issues such as women's reproductive or personal health issues that may result in restricted access to healthcare (Vlassoff, & Moreno, 2002).

It has been found that nurses in primary health care settings do not make use of available interpreters but instead rely on family members to assist in the interpretation process and therefore seen as not attempting to improve the health care service they render (Gerrish et al., 2004). The authors concluded that minority ethnic communities in the UK are disadvantaged when health care providers do not use interpreters when available, or when they do not demand the use of fully trained interpreters when they are not provided. Training for health care workers in how to use interpreters was also highlighted as important as it cannot be assumed that the mere presence of interpreters will improve health care delivery. Training of interpreters not only on ethical issues such as truthfulness and confidentiality, but also on health-specific issues, are viewed as important to improve the quality of health care delivery (Gerrish et al., 2004). According to Harmsen et al. (2003), selecting a competent translator is a very complex task. Medical terminology could pose some problems as it may be very difficult to find a perfect translation for words or phrases as some medical words may lose their meaning when translated (Papadopoulos et al., 2004; Ny et al., 2008). The quality of service delivered by health professionals will therefore depend largely on the quality of interpretation that is done (Gerrish et al., 2004).

Most refugees who use the services of formal interpreters report some level of satisfaction with their general practitioners (Wiking, Saleh-Stattin, Johansson & Sundquist, 2009) as opposed to contexts where interpreters lack skills or cultural knowledge of the patient and the health setting. In South Africa, language barriers contribute to the failure of

treatment among forced migrants and migrants for whom English is not their first language (Apalata et al., 2007). Strong support for the use of interpreters in public hospitals to avoid inappropriate treatment to refugees was evident in the study of Apalata et al. (2007). As refugees and asylum seekers from the DRC are all French speaking, it is likely that language my pose a barrier to effective and acceptable health care delivery.

2.4.4 Influence of cultural health beliefs in health care services

Various inter-cultural challenges apart from language may impact health care delivery in contexts where healthcare providers and patients are from different cultures. Host countries may experience challenges in providing services to forced migrant populations holding different illness representations that may complicate health care service delivery (Moroka & Tshimunga, 2009). People of different cultures may describe pain and distress in different ways using different nuances and unusual metaphors that is not commonly understood that could contribute to misunderstandings during the consultation process (Gany et al., 2013; O'Donnell et al., 2007; Harmsen et al., 2008). Cultural barriers related to gender may impact the utilisation of health care services. For example health care seeking for reproductive health may be impeded as traditional practices may inhibit women seeking these services (Kronfol, 2012). In situations where health care workers and patients are from different cultures it is likely that open communication will be inhibited due to uncertainties about appropriate words to use and permissible questions to ask during consultation (Asgary& Segar, 2011).

Knowledge about different cultural beliefs and practices as well as supportive attitudes towards people from different cultures may help healthcare providers to better understand the minority group during discussions and consultations and to enhance refugee healthcare access in the host country (Clough, Lee, & Chae, 2013). It would also be possible to assess the quality of health care service delivery through the investigation of health care workers' cultural knowledge, beliefs and attitudes regarding clients or patients form different cultures (Gele, Torheim, Pettersen, & Kumar, 2015).

2.4.5 Knowledge of the South African health care system

One of the major barriers faced by forced migrants when seeking healthcare is a lack of knowledge about how the system functions and where to go for help (Ascoly, van Halsema, & Keyser, 2001). This has direct implications for how migrants meet their health needs and the way the health system is utilised.

Public and Private health care system: The South Africa healthcare system is divided into two sectors namely the public and private sectors. The private sector serves primarily those with a higher socio-economic status and or with a medical aid, while the public sector are mostly directed at service delivery to vulnerable groups such as the poor local population and refugee and asylum seekers (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009).

Referral system: This system is directed towards a reduction of the care burden on tertiary level health care services (hospital services) by more efficient functioning of Primary Health Care (PHC) clinic facilities. The aim is to ensure that minor ailments are addressed at the PHC level and that hospitals are utilised for secondary and tertiary level care only. This implies that all must first seek help at the PHC level before they can then be referred to for

further care if needed using a referral letter. Patients who attempt to seek help at the clinic might be referred back to the PHC facility unless it is a medical emergency. There seem to be a common perception that the treatment offered at hospitals are superior to that offered at PHC clinics and therefore many may go directly to the hospital before seeking help at PHC level (Becker et al., 2012). A lack of awareness among refugees about this process may cause frustration among refugees not being aware of this referral system and then to be referred back to PHC services (Apalata et al., 2007).

Another obstacle identified by migrants/forced migrants is *clinic card system* used for child health services offered in the clinics. Child healthcare services work on a system of 'clinic cards' which are kept by caregivers and updated by health care workers. The patient files that are stored at the facility which the child attends for growth monitoring and immunisation. Should a caregiver not be in possession of a clinic card, they have referred back to where the child was issued with these cards to enable them to deliver care to a child, (Hugo & Louw, 2006). In the interim, the child cannot be seen until the card is located or if necessary, re-issued (Nkomo et al., 2015). It should be noted that this can be problematic as refugees are mobile and move to seek better opportunities between cities resulting in a greater likelihood for documentation to be lost in the process.

Long waiting queues especially in PHC settings might also impact on perceived accessibility to health care. It has been reported where clients have to wait longer than an hour to see a health care provider; this could result in a loss of faith in the quality of health care due to stress and anger (Zihindula et al., 2015). However, the long waiting times in South African PHC clinics is an everyday experience and well documented i.e. reproductive health care (Kibiribiri, Moodley, Groves & Sebitloane, 2015).

It has been found that long waiting time for health care impact negatively on health care access and satisfaction as refugee women/care givers perceive this to impact negatively

on their other household responsibilities such as child care and food preparation if they spend most of the day waiting to receive health care (Clough et al., 2013).

Local Hospital policies related to health care costs: According to a study conducted in a Johannesburg hospital in South Africa, Teagle (2014) found that local hospital policies applied to foreign nationals including refugees may impede access as they are required to first pay the full cost of their treatment before they will receive healthcare treatment. Evidence for this was in a pricing list in one hospital that stipulated an amount of R5 000-00 to be paid in advance by foreigners for emergency/outpatient services, R15 000-00 for maternity services, R125000-00 for cardiology services. In another hospital, foreigners are charged a minimum of R1 500-00 for emergency healthcare services and R8 000-00 for maternity services. These practices seem to contravene the "free services" at public health facilities that provides healthcare services to refugees and asylum seekers as enshrined in the Refugee Act 130 of 1998 in the South African Constitution. Access to healthcare service to refugees and asylum seekers should be similar to that of South African Citizen and without any discrimination due to their documentation (Teagle, 2014). While the Alma Ata declaration aspires to ensure the delivery of essential healthcare services to all, vulnerable groups globally are yet to experience equitable health care services (WHO, 2010).

In addition, the power dynamics between doctor/health care provider and client/patient may also impact the relationship and communication process and thus health care outcomes.

2.4.6. Health worker attitudes towards refugees or migrants

The attitudes of health care workers toward migrants and refugees can be linked to their understandings of refugee status and their accompanied legal rights including eligibility

to free, accessible and quality health care services as delivered to South African citizens (referred to above); their own levels of work satisfaction where greater levels of satisfaction is expected to translate into better health care deliver (Pillay, 2009) as well as personal prejudice in the form of xenophobia evident in recent expressions of violent attacks on foreign nationals, looting of businesses and home as well as verbal abuse – all which received wide media coverage and caused public outrage (Teagle, 2014). Medical xenophobia in South African has also been reported (Alfaro-Velcamp, 2015; Crush & Tawodzera, 2014; Zihindula et al., 2015).

The South African public health care service is generally characterised by being inefficient and ineffective as well as under-resourced and overused (Pillay, 2009). Unsupportive work environments, inadequate infrastructure, a shortage of staff in relation to high patient loads and poor salaries among health workers result in unhappy and unmotivated staff and this impact negatively on health care delivery including long waiting times for patients before they are attended to (Moyo, 2010). Work dissatisfaction is also a major reason for the turnover rate among nurses which in turn impact negatively on service delivery as this contributes to a higher workload among those who remain in the service which in turn leads to low morale and a decrease in productivity and implied inefficient health care delivery (Pillay, 2009). Therefor health care providers that are unhappy in their work context tend to give a poor quality and less efficient health care service than others (Moyo, 2010; Pillay, 2009).

A positive correlation between professional satisfaction and patient satisfaction as well as health outcomes had been found. In the national survey conducted by Pillay (2009) among professional nurses in the private and public sectors, nurses in the public sector were generally dissatisfied with their remuneration, the workload and the resources available to

them. The author argued that this has serious consequences for the efficiency and effectiveness of the South African health care system unless government take cognisance of nurses' needs and take active steps to address their concerns. It can therefore be argued that nurses' work dissatisfaction is likely to impact on health care delivery to refugees as migrants and refugees might be seen to contribute to the already high workload in public sector health settings. Negative attitudes towards refugee patients could therefore impede accessibility to much needed health care services.

2.4.7 Medical Xenophobia

According to Gilmore (1998) when non-nationals are deprived of health care opportunities this not only endangers their own health, but endangersall public health efforts. It should be noted that integrated refugee health services is proclaimed by the DoH but its success is questionable as outlined below. In addition, in the recent developed National Health Promotion Policy and Strategy 2015 to 2019 (South African Department of Health, 2015), refugees and migrant workers were identified as vulnerable and marginalised groups with special health needs that should be considered in the planning and implementation of health promotion interventions.

A Human Rights Watch Report (HRW, 2010) describes how ignorance, lack of documentation, and fear of deportation have prevented many new refugees and asylum seekers from seeking medical treatment, although the South African law and policy allows such individuals to access healthcare services. A similar finding was reported by Apalata et al. (2007) in their study among refugee's perceptions of quality of health care services in Durban. In the HRW Report (2010) it was reported that refuges and asylum seekers who seek healthcare from hospitals are often not treated well, sometimes verbally abused by healthcare workers and charged unlawful fees or denied care altogether (HRW 2010). The

same reported further revealed “migrants to South Africa are abused in transit, attacked upon arrival, and then denied care when they are injured or ill. The South African government should be ensuring that these people get the care they need, and are entitled to, under the country's constitution." (HRW, 2010, p 12)

In an extensive study, migrants from neighbouring Zimbabwe informed Human Rights that it was difficult accessing healthcare services due to lack of basic information, lack of appropriate documents and financial resources. The problematic nature of “illegal refugees” is likely to impact on both healthcare access and might pose health challenges for the communities in which they reside in the case of communicable diseases including STIs and HIV in particular (Robinson, 2006). According to the study, rape survivors are required to file police reports before they get any emergency medical treatment, however, they hardly follow this procedure for fear of deportation. The Ministry of Health in South Africa has acknowledges the rights of refugees to obtain healthcare, but a report from the Human Rights Watch (HRW, 2010) indicated that healthcare workers have repeatedly violated this provision. The same report showed that refuges are discriminated against on the basis of their nationality and or the lack of proper documentation. Permanent disabilities as a result of attacks based on nationality may be complicated by xenophobic discrimination in healthcare settings generally – this is referred to as medical xenophobia. This is can be described as negative attitudes and practices of health care workers towards migrants and refugees (Crush & Tawodzera, 2011). Because of the widespread xenophobia in the South African society, South Africa has been labelled as one of the most migrant unfriendly countries worldwide (Crush & Ramachandran, 2010).

Additionally, in urban centres in South Africa refugees and migrants are often placed in unsafe temporary accommodation, which is associated increased risk of getting infection with communicable diseases. This can also lead to interruption of treatment for chronic

illness particularly for those who may be in need of uninterrupted access to ARV (Robinson, 2006), and often have inadequate nutrition because of poverty. Illness becomes more severe or resistant to first-line drugs when let untreated. This may lead to the development of preventable disability which becomes more costly (Apalalata et al., 2007). These aforementioned issues could further affected the already overburden South African healthcare system. Shaeffer stated: “discrimination against foreigners is institutionalised in South Africa's health care system and that people seeking care should not be subjected to abuse” (HRW, 2009).

It is established fact that migrants and refugees depend on well-established networks from their country of origin for basic necessities such as food, housing and even employment, (Apalata et al., 2007). However, access to affordable health services is solely dependent on accessibility of health care services offered by the provincial DoH. In South Africa, a study has found out that less than half of foreign nationals ever need healthcare services, and about a third (30%) of migrants reported experiencing difficulties in order to access health services (Vearey & Richter,2008). Another study also reported that patients were often “required to show identity documentation, proof of residence status and evidence of a home address before treatment is provided” (Crush & Tawodzera, 2011, p. 2). In an earlier study among refugees in Durban, Apalata et al. (2007) reported that even refugees with valid documentation may be rejected by health care workers and more so female clients. The most vulnerable groups of asylum seekers and refugees, mainly women, children, and disabled persons, are the most affected by the denial of health services once they have entered South Africa (Crush & Tawodzera, 2014).

While medical xenophobia presents itself openly it may also be more subtle and nuanced. Studies have reported that migrants and refugees experience verbal insults and abuse as well as discriminatory remarks from health workers (Crush & Tawodzera, 2000,

Zihindula & Meyer-Weitz, 2015). These studies further revealed that health care providers were reported to be reluctant to communicate in English with patients of foreign nationality, or sometimes require the patient to seek for a "translator" who is fluent and under IsiZulu (Zulu language) (Crush & Tawodzera, 2000, Zihindula & Meyer-Weitz, 2015). In other studies health workers expected black clients to be Zulu-speaking and would therefore conduct the consultation in isiZulu including health education (Zinhindula & Meyer-Weitz, 2015; Apalata et al., 2007). For instance, Apalata et al. (2007) found that refugee women in particular face various challenges as counselling and antenatal education is only done in isiZulu and HIV testing is done without informed consent.

In reference to the above discussion, refugees and asylum seekers would have to wait until all South African nationals had first been treated before they could be attended to, and sometimes would have to make financial commitment of the basis of coming from a different country (Crush & Tawodzera, 2011). Although it is national policy that access to ARVs should be done irrespective of nationality of the person living with HIV, refugees and asylum seekers have experienced difficulties y in obtaining ARVs for HIV treatment (DoH, 2010). However, a key challenge HIV treatment has been issues related to cultural sensitivity pertaining to HIV status and confidentiality of HIV status, as healthcare workers including as nurses have been found to openly disclose a patient HIV status for the first time openly in the waiting room (Vearey & Richter, 2008). These authors also highlighted the various challenges in the implementation of healthcare for all people living in South Africa, such as the shortage of qualified healthcare workers which contribute to long waiting times, an inadequate budget allocation to public health care facilities, which all in turn impact negatively on migrant and refugee health service delivery (Teagle, 2014; Vearey & Richter, 2008).

Power dynamics between doctor/health care provider and client/patient may also impact the relationship and communication process and thus health care outcomes (Mirza et al., 2014). It is expected that health workers should demonstrate respect for patients' concerns, provide patients them with appropriate information, demonstrate empathy, and develop a trusting relationship with their patients (Wong & Lee, 2006). These are shown to be important aspects in patient satisfaction and effective medical treatment adherence (Wong & Lee, 2006). Factors that impact negatively on patient satisfaction include the available time afforded to patients by doctors and the dismissal of patients concerns (Wathen & Harris, 2007). In Canada, women indicated they are reluctant to contradict doctors for fear of being given a bad name (Wathen & Harris, 2007) while the fear of being labelled as troublesome may inhibit patients to ask all the questions they have (Andersen, 2004). A lack of time by health workers will also limited opportunities for patients to ask questions and for health workers to carefully respond to patient questions resulting in dissatisfaction with the consultation process due to unmet information needs (Wathen & Harris, 2007). The quality of the relationship and communication process between patients and healthcare workers are important processes in meeting patient's healthcare needs (Wathen& Harris, 2007; Wong & Lee, 2006).

The troublesome relationships between refugees and health workers at particularly PHC level have negative consequences for refugee children. The poor nutritional status of refugee children and the limited pre- and post-natal assistance to mothers have been cited as one of the consequences of the mortality rate among refugee children in the study of Apalata et al., (2007) i.e. a mortality rate of 16 children per 100 live children borne from the sample of women had died before the age of five.

Against this background, the general dissatisfaction expressed with health care services is understandable (Apalata et al., 2007; Crush & Tawadzera, 2014; Zihindula, Meyer-Weitz & Akintola, 2015). Satisfaction measures the patient's "cognitive evaluation and emotional reactions influenced by perceptions of quality, convenience, physical environment and anticipated outcome of health care" [Cleary & McNeil (1988) as cited in Halfon, & Hochstein, 2004). People who are in dire need for health care might be more critical of healthcare received than those who are less urgent need for care. A possible explanation is that those with greater needs for services have more opportunities to be disappointed as they have more information needs about health condition, the diagnoses and treatment options (Schlesinger, Drusss & Thomas, 1999). Patient satisfaction with health care has been found to be positively related to treatment adherence and seeking of health promotion services (Halfon, & Hochstein, 2004).

Different levels of satisfaction have been found between public and private health care providers. High levels of refugee dissatisfaction with public health services were common while more positive attitudes were expressed with private health care services (Apalata et al., 2007; Pillay, 2009). However, studies showed a different picture for South Africans as greater satisfaction with health services are experienced (Peltzer, 2009; Ramela, 2009).

The stark absence of health worker perspectives on health care delivery to refugees also highlighted by Crush and Tawodzera, (2014) raise questions about the willingness of the departments of health to engage with the matter. General aspects related to parents or caregivers perceptions of health care delivered to their children will be elaborated on below.

2.5. Parents and caregivers perceptions of child health care services

Studies exploring refugee care givers' perceptions including level of satisfaction with health care services rendered to their children seem particularly sparse with most studies being conducted with parents or carers of children with special needs or living with disability. Understanding the perceived quality of child health care and related satisfaction enables the health care sector to improve the efficiency of health care delivery through the insight into the particular needs and the tailoring of services accordingly (Fawley-King, Haine-Schlagel, Trask, Zhang, & Garland, 2013).

Perceptions of care have focussed primarily on parental experiences with the different processes of care (Adler, Salanterä, Leino-Kilpi, & Grädel, 2015; Halfon, & Hochstein, 2004). The role of parents or care givers of children is important in evaluating healthcare quality particularly when access is limited (Shilling, Bailey, Logan, & Morris, 2015).

Different steps are important when caregivers need to evaluate their children's healthcare needs (Coyne et al., 2015). Firstly they must be able to identify that their child has a problem and make a preliminary diagnoses based on their child's symptoms. This is normally followed by seeking advice either from family members, neighbours and preparing to seek help from professionals. The pharmacists is often consulted, and then the clinic, doctor or hospital. These decisions are based on caregiver's diagnoses and perceptions of seriousness or urgency of the condition. In the last instance, the parents or care givers need to deal with possible barriers relating to health care access e.g. financial, time and information about the healthcare system or services delivered. Parents or care givers previous experiences with the health care services will inform their health care seeking decisions (Fawley-King et al., 2013). The quality of the relationship between health care

providers and parent/care givers are therefore critical in facilitating timely provision of health care to children (Epstein et al. 2015). The relationship should therefore be characterised by collaboration and trust to address the self-identified needs (Epstein et al. 2015). A study conducted in the Canada, emphasised the collaborative and trusting partnership between parents and healthcare workers further characterised by mutual respect, open sharing of information, and shared decision-making with cognisance of particular family circumstances and needs (LeBlanc, Naugler, Morrison, Parker & Chambers, 2014).

In conclusion, perceptions about the quality of care received from health care services are important in the improvement of quality health care services as it allows for better insight into their practices and particular problem allowing opportunities to improve patient care. From a human rights perspective, good quality of healthcare can be considered to be the right of all patients and the responsibility of health care workers

2.6 Social networks and access to healthcare

Strong social networks and social cohesion among groups have been linked to improve health and wellbeing. It has been argued that ethnic minority groups' physical and mental health are enhanced by living in areas with a high concentration of their own ethnic group known also referred to as ethnic density (Becares, Nazroo & Stafford, 2009; Pickett & Wilkinson, 2008; Shaw et al., 2012). The studies that were conducted to better understand the pathways to improved health in these contexts, often poorer than other areas, seem to suggest that better health is through increased social support (Das-Munshi et al. 2010), social cohesion (Stafford, Bécares, and Nazroo 2010) and because of a decreased likelihood of experiences related to racism and discrimination found to impact health negatively (Bécares, Nazroo, and Stafford 2009; Das-Munshi et al. 2010). Ethnic density among refugee communities may therefor play a protective role in their health and wellbeing in a

context where xenophobia is widespread. On the other hand, this social isolation may further hamper integration into South African society, already limited by a language barrier.

Social cohesion and has been viewed as an important element of social capital. The strengthening of social capital has been argued to offer support, buffer difficulties, improve health and enable opportunities through supportive relationships within the group, with others and external agencies (Kawachi, Kennedy, Lochner & Prothrow-Stith, 1997; Kawachi & Berkman, 2000; Lomas, 1998; Pickett and Wilkinson 2008; Putnam, 1995; Shaw, Atkin, Becares, Albor, Stafford, Kiernan, Nazroo, Wilkinson, Pickett, 2012). Social capital is linked to ethnicity as strong social networks and support to members of the ethnic group often exists (Bankston and Zhou 2002). Kawachi and Bergman (2000, as cited in Becares & Nazroo, 2013) argued that social capital, that includes notion of social cohesion and supportive networks, impact health through influencing health related behaviours, access to services and facilities and by impacting psychosocial processes. In the mixed method study of Becares and Nazroo (2013) social capital was not found to mediate the association between ethnic density and mental health. The relationship between social capital and ethnic density varied as a function of the measurement of social capital in that where it was measured at a neighbourhood level there was an association but when measured at an individual level, no relationship was found.

2.7 Theoretical Frameworks

The conceptual framework for health care access of Peters, Bloom, Walker, Brieger, and Rahman (2008) (See Figure 2) and the Household Resources Model (Wallman & Baker, 1996) depicted in Figure 1 were used to understand the factors impacting health care access. The model of Peters et al. (2008) addresses the compromised health service access of people in poor countries and contexts. It is argued that while a lack of financial resources create barriers to access health care, the complexities of environmental aspects in combination with individual and household characteristics denote poverty which impact on other factors that may inhibit access. The cycle of poverty is viewed to impact health and wellbeing which in turn maintains ill health and access to health care. Quality of care is central to health care access which in turn is determined by geographical accessibility, availability of service, financial accessibility, and acceptability of service. The policy and macro environment in combination with individual and household characteristics determine health status but also impact health care access. Due to the relatively low level of socio-economic status and available household resources (Vearey & Richter, 2008) the health status and general wellbeing of migrants and refugees are compromised.

The Household Resource Model (Wallman & Baker, 1996), (See figure 1) explains accessibility to healthcare services in terms of material resources (MRI), investment potential (IPI) and social resource (SRI).

Material resources refer to the possession of any material resource (e.g. money) which allows for easy or better access to healthcare when required. For example the availability of money makes it possible for one to go to the clinic when ill or to buy medicine from the pharmacy when required. Actual money income includes all sources of income to the household.

Investment potential describes the skills and capacity of people i.e. competencies of the person, characteristics of the person, education and communication skills that will enable the person to generate an income or obtain credit when it is needed. Investment potential can be linked to one's social status which enables the person to gain the necessary social support needed to convert capabilities into financial gains to respond to needs.

Social resources refer to the extent and status of social networks and connections. According to Barnes (1954), **s**ocial networks can be defined as "a field of relationships between individuals." This can also be also defined as "the flow of reciprocal exchange of goods, services, and economically valuable information" (p. 132). Social resources are thus viewed as a link between people that enable support among people that share a common destiny, purpose and challenges.

Social networks among refugees' play important roles. For example it assist in decisions to seek refuge in a particular country obtain information, including health care related, and social support and even employment in the new host country ((Martin, 2002). These social and economic networks are critical for the survival and integration of refugees in the host countries (Martin, 2002; Taylor, 2009). The refugee networks forms interpersonal ties of kinship, friendship, and shared community origins that connect refugees, former refugees and non-refugees in countries of origin in the new host country (Apalata et al., 2007; Taylor, 2009).

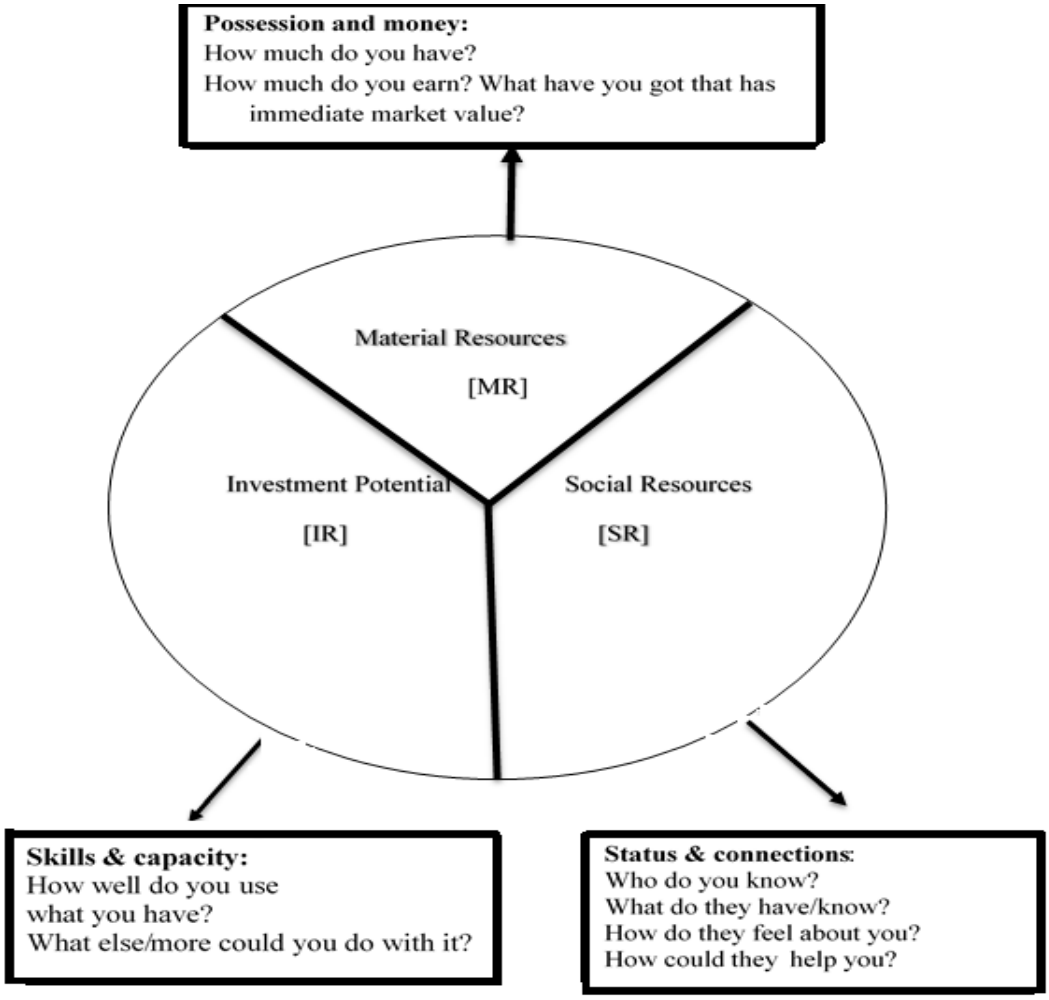

Fig.1: Conceptual framework for examining access to health services (adopted from Wallman & Baker, 1996)

Apart from household resources, the *policies* regulating access to health care of refugees in South Africa and the implementation of these policies at the health care service delivery level is argued to play a role in refugee health status but also access to health care. The role of xenophobia in South Africa in this regard cannot be ignored as this will further increase their health and wellbeing vulnerability (Alfaro-Velcamp, 2015; Crush & Ramachandran, 2011). The components linked to quality of health care as explained by the conceptual framework of Peters et al. (2008) are outlined hereunder:

Geographic accessibility refers to the distance from home to the health care facility or travel time to the healthcare facility. This has been found to impede health care access if the distance and travel time is too length and costly (Hjortsberg, 2003). It may also refer to supply of drugs and equipment to health care facilities and communication services especially during emergencies and is particularly important when facilities are in remote areas. In this study geographical access is unlikely to be a problem as the care givers studied live in Durban and various public health care facilities are available.

Availability refers to the right type of care available to anyone who is in need of health care including (refuges, migrant, vulnerable groups such as children and women). The opening hours of health care facilities, the long waiting times for service delivery, lack of human and financial resources that negatively impact service delivery such as time of services delivered and the waiting time for services that is considered as reasonable by the user, receiving the proper type of service and treatment. Equitable services may be considered here. In South Africa, healthcare availability to refugee still need to be improved as various research conducted in this regard has pointed out some levels of dissatisfaction with healthcare delivered by local public health facilities to refugees as discussed earlier (Apalata et al., 2007; Crush &Tawodzera, 2011; Crush &Tawodzera, 2014; Zihindula & Meyer-Weitz, 2015).

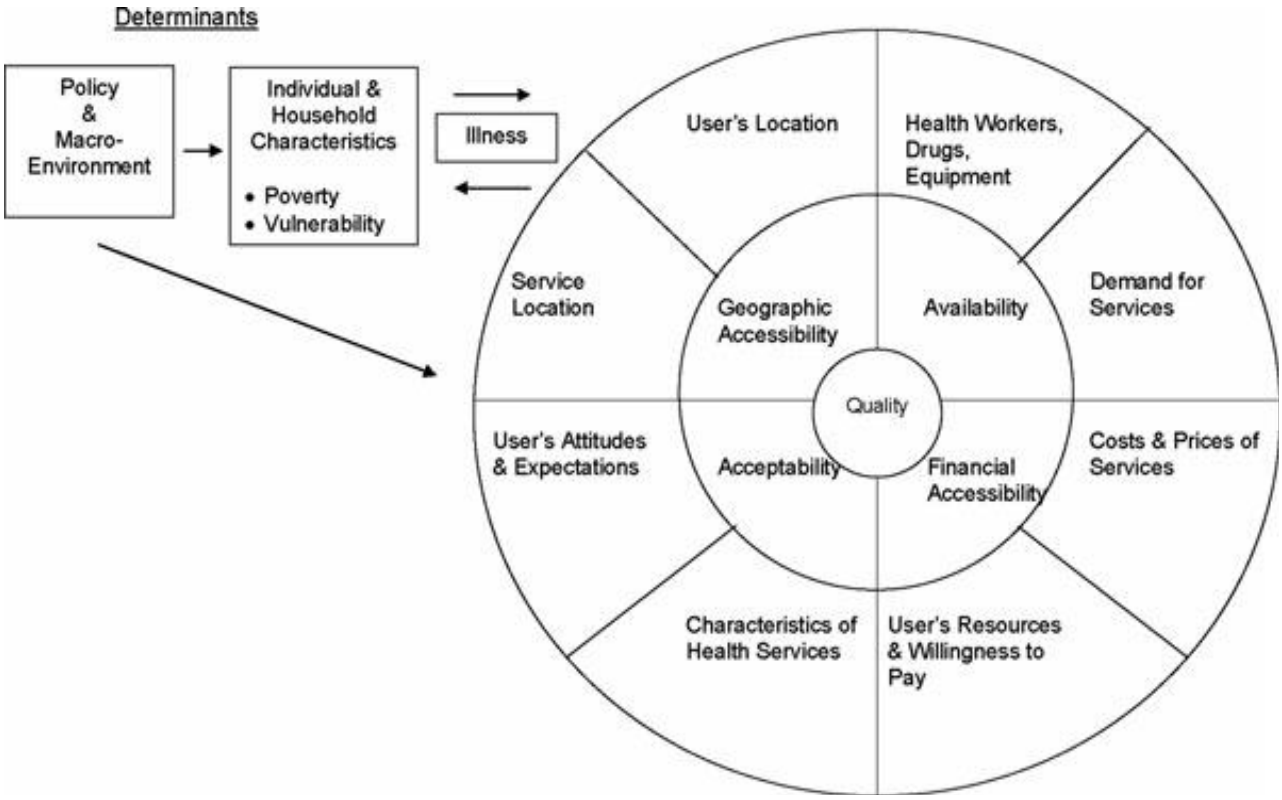

Fig 2: Conceptual framework for assessing access to healthcare services (Peters et al., 2008)

Acceptability of healthcare services is assessed by the user's views and level of satisfaction, their attitudes, beliefs and expectation. The characteristics of healthcare facilities can also be tested by the consideration of different social and cultural aspects by individual or communities users. Refugee may face cultural barrier in the host country once there is difference withtheir home culture. For example, refugees from Democratic Republic of Congo's have a culture which may be totally different from what practiced in South Africa, something that could have negative consideration on healthcare services. For example the need to present with identity documentation or in the case of refugees the necessary documentation before one is able to access any free public health care service. This poses a challenge to some refugees in South African due to a lack of proper documentation allowing

them to stay in South Africa. Fear of being reported to the authorities by healthcare workers may impact access

Financial accessibility: According to Peters et al. (2008) financial accessibility can affect access to healthcare where applicable and refers to the cost of the service and the user's ability to pay for these services. Users with lower levels of income such as refugees and other vulnerable groups may face major barriers to access healthcare services due to their economic situation. In some countries where healthcare services are provided free of charge (i.e. in South Africa healthcare services at the local facilities are free of charge) financial costs due to transport to the facility may impede access. It should be noted that although a services might be free of charge, the quality of healthcare might not necessarily be approved by the users and therefore pose challenges to acceptability (Belvedere, Pigou, & Handmaker, 2001).

Quality: This is at the centre of the model and expressed in relation to the four factors namelydeterminer healthcare satisfaction is obtained when quality of healthcare is achieved, which is not only based on the healthcare fields but also based on the environmental sector, social-economic in the household (Yiran, Teye & Yiran, 2015)

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter outlines the method that was used to conduct the study. The purpose of the study was to investigate refugee parents/or caregivers' perceptions regarding health service delivery to their young children. In this chapter, the study setting, design, sample size and sampling procedure, research instrument as well as procedures used for the data collection and data analysis will be discussed.

3.2 Research Setting

This study was conducted in Durban EThekwini Municipality, KwaZulu-Natal. Durban is a coastal metropolitan area on the east coast of South African; within the province of KwaZulu-Natal with a population of 3.5 million people in (Amisi, 2006). It is one of four metropolitan areas in South Africa and is one of the strongest municipalities in the country from the point of view of human and financial resource. The metropolitan area is characterized by high levels of poverty and unemployment and historical marginalization of the poor. Due to the country's legacy of apartheid or separate development of the various race groups, the socio-economic divides described are highly radicalised. This manifests spatially in massive formal and informal low-income. It was estimated that in 2010 that from the 270, 671 refugees and asylum seekers in South Africa in 2010, the largest number from this group are located in Durban due to the perceptions of emplacement and access to small business (Refugee Social Services (RSS), 2010).

3.3 Research Design

The broad framework of the research study can be considered to be applied research as it allows the researcher "to bring personal insights andexperiences into any recommendations that may emerge, due to theresearchers' ability to understand the problems whilst conducting the fieldwork" (Patton, 2000, p.15). Applied research is described by Burns and Grove (2001) as a scientific investigation conducted in order to generate knowledge that will improve or influence clinical practice. Sim and Wright (2002) reinforce this definition and state that, by conducting applied research, practical solutions can be offeredin order to address specific problems and issues.

To this end, the study makes use of an explanatory mixed method design in which the quantitative cross-sectional survey was followed by a small qualitative study. These methods were chosen because it allowed the researcher an opportunity to understand different aspects of the quantitative data in more detail (Creswell & Plano-Clark, 2011). As the study investigated quantitatively refugee parents or caregivers' perceptions of their children's health status, the experiences in seeking health care as well as accessibility and satisfaction with health service delivery are explored qualitatively. The added value of the qualitative component was to gain a deeper understanding of the care givers' perceptions and experiences. The characteristics of quantitative and qualitative research approaches will be address in more detail below.

3.3.1 Quantitative survey

A quantitative study is designed to produce numerical data that can be analysed statistically to provide patterns, associations, and trends (Shaughnessy, Zechmeister & Zechmeister, 2012). A cross-sectional survey was used and usually comprise of different individuals who

are examined pertaining to various variables at approximately the same point in time (Terre Blanche, Durrheim & Painter, 2006).

3.3.2 Qualitative study

Qualitative methods offer the opportunity to obtain an in-depth understanding of individual's experiences conducted in a natural setting to allow the researcher to gain a "holistic picture" of the phenomena in question (Creswell, 1998, p.5). These approaches also allow researchers to overcome the limitations of structured questions (common in quantitative surveys) by using open-ended questions in which participants are encouraged to openly share their experiences and perceptions using their own words (Neuman, 2011). Through this qualitative process, a deeper understanding of participants' perceptions, their behaviours and the different meanings they attach to these experiences can be obtained (Ulin, Robinson, Tolley & McNeill, 2002). It can therefore be argued that qualitative methods using in-depth interviews are valuable in capturing participant experiences and the meaning making of these experiences (Patton, 2000).

3.4. Sampling and Participants

A non-probability purposive sampling in combination with snowball sampling was used to recruit participants in this study as it allowed the researcher to select participants who are able to provide rich information about the phenomenon that is being studied (Creswell, 2005). This sampling strategy was used to select the research participants who are parents or caregivers of refugee children (aged 0 to10 years), from the Democratic Republic of Congo living in Durban, KwaZulu-Natal. Within the community of refugees from the DRC, the different networks that exist were used by the researcher to gain access to the parents/caregivers before approaching them to seek their participation in the study.

Participants were included in the study if they met the inclusion criteria: being a DRC refugee living in Durban, aged 18 years and over, had a child or taking care of other children and willing to take part in the study. Based on the inclusion criteria, 120 parents/or caregivers of young children (up to ten years old) were recruited for the **quantitative** phase of the study. Ten of the participants of the quantitative study were randomly selected for the **qualitative study** to provide further information on the different aspects explored in the quantitative study. Principles of data saturation were applied and after about ten interviews, no additional data was obtained (Neuman, 2011).

3.5. Research instruments

The development of the research instruments used for the quantitative and qualitative studies is presented in this section. See Appendix 3 for the research instrument used.

Quantitative questionnaire

Polit & Beck (2004) define a research instrument as a device used to collect data, for example, a questionnaire, test, or observation schedule. For the purposes of this study, a structured interviewer-administered questionnaire was developed in English and translated into French to collect quantitative data from the parents/caregivers.

In the absence of an ideal instrument, the researcher self is responsible to compile a relevant instrument (Polit & Beck, 2004). The questionnaire was developed based on a good understanding of the literature, the theoretical framework and the aims and objectives of the study. The questionnaire consisted of five sections namely: Bio-demographic information, socio-economic status and living standard, medical history of children, satisfaction and experiences with healthcare services and refugees' networks and social support. The questionnaire can be viewed in Appendix 4

Section A: Demographic Characteristics

Demographic characteristics of both respondents and their respective children were investigated. The information gained includes age, gender, level of education, religious affiliation, marital status, English language proficiency and number of children.

Section B: Socio-economic status including household resources

The social-economic statuses of participants (parents' caregivers of refugees' children) were obtained with items regarding their employment status and living standard e.g. Are you in fulltime employment? and Are you short of money for basics like food and clothes? Do you have enough money for basic things like food, clothes?

With regards to household resources, the dimensions suggested by Wallman and Baker (1996) pertaining to the theoretical framework discussed in the previous chapter regarding the informal economy of health, were used to develop items. The items related to the dimensions of available material resources, social resources, including bridging social capital and investment potential using a response format of "Yes" and "No". See also the index construction below.

Section C: Refugee Networks and Social Support

This section elicits information about the availability of support from other refugees living in Durban. Some of the questions asked were: Have you received any help form your refugee community? How often do you meet with your family members? Questions about sources of information about healthcare such as friends, family members, people from church were also asked.

Section D: Medical History

This section of the questionnaire assessed the health status of both the caregivers and the children under their care. Some of the questions asked included: “Have your child been immunised?” and Where were your child immunized? The response format for these questions was in the form of “Yes or No”. Participants were also asked the type of vaccination children received and at what age this was done.

*Section E: Accessibility, Experiences and Satisfaction with the Healthcare Services*Different questions were asked to assess parents’ and caregivers’ views about health care seeking behaviours for their children and the accessibility of health care service. Perceptions and experiences with private and public health care services specifically with regards to parents or caregivers’ level of satisfaction. Items were adapted from the National Survey of Early Childhood Health (NSECH) used in the study of Halfon & Hochstein, 2004) pertaining to the satisfaction with health care for young children. The questions assessed parent’s general satisfaction with the health care services but also the healthcare service consultation process. Two rating scales of 0 to 10 were used to assess their overall satisfaction with the health care services provided by public clinics and private doctors. This overall satisfaction measure was also used by Halfon and Hochstein (2004) in their study and argued to be generally used when levels of satisfaction are investigated.Apart from this global rating to measure satisfaction with health care, the National Survey of Early Childhood Health (NSECH) include items that tap into parent reports on the perceived adequacy of time and information sharing during the consultation process and were also included (Halfon & Hochstein, 2004). (See the research instrument in this regard). These questions were measured using a Yes and No response format.

Qualitative Interview Schedule

For the qualitative study, an interview schedule was developed in English and translated into French, based on the key research areas of the quantitative research instrument. Open-ended questions were developed in this regard to elicit in-depth information more detailed information from the participants on the quantitative areas that were investigated. Some of the questions asked were: What are the kind of illnesses that your children suffer from for which you sought medical treatment?, How did the health care workers made you feel when you visited the clinics? Why did you choose the private doctor? What were your experiences with the clinic services?

3.6. Data Collection Procedures

After ethical clearance was obtained from the University of KwaZulu-Natal Social Science Research Ethics Committee, the quantitative data was collected from May to July 2013 and the qualitative data was collected early in 2015 after the basic analysis of the quantitative study were conducted. The data was collected using French, the official language of the DRC.

Quantitative study: Cross sectional survey

Caregivers were approached and participation in the study was requested. The aims and objectives of the study were explained. For those who agreed to participate in the study, an interview was scheduled with the participants at a place and time most convenient to them.

On the day of the interview, informed consent was sought by first explaining the aims and objectives of the study (as was done during the initial recruitment stage) and the ethical principles relevant for research were discussed namely the voluntary nature of participation in the study; their rights to withdraw from the study at any time during the course of data

collection without any negative consequences to them as well as the confidentiality and anonymity of the information obtained from them. It was made clear that no names or any identifiers would be obtained that would enable the linking of data received to the particular individual and that only pseudonyms would be used in the data.

The administering of the questionnaire took an average of 35 to 45 minutes. Permission was sought to approach the participants at a later stage for a follow-up interview at a later stage.

Qualitative data collection procedures

The 12 randomly selected participants who agreed to participate in the follow-up qualitative interviews were approach and a date and time were set for an interview at their convenience. Informed consent were sought by explaining the aims and objectives of the study, the voluntary nature of participation in the study, the confidentiality and anonymity of the information provided as well as the their right to withdraw from the study participation at any time during the interview without any negative consequences. Permission was also granted for the interviews to be audio recorded. The interviews lasted for an average of 60 minutes for each participant. The interviews were conducted in French, the language understood by the participants. The qualitative data collection lasted for another 4 weeks after the quantitative data was analysed during the early part of 2015.

3.7. Data Analysis

In this section the analysis used for the quantitative and qualitative studies will be addressed. The section will be concluded with aspects related to validity and reliability.

3.7.1 Quantitative data analysis

In this section, the data processing will be explained, followed by recoding, the construction of measures and statistical tests conducted.

Quantitative data processing

The statistics package for Social Sciences (SPSS) version 21 was used for data analyses. The data was entered into Microsoft Excel and then imported into SPSS. Quality control of the data was conducted to ensure that it was correctly coded and imported into SPSS.

First frequencies were conducted for all items in the questionnaire and then descriptive statistics were conducted to explore the nature of the data and the central tendency of the data. The frequencies were also used to describe the sample and particular research questions. Recoding was conducted for analysis as explained below.

Recoding of variables

Recoding was done to improve the response categories for analysis as follow:

- *Age group* was recoded into four groups: 1= 23 – 29 years; 2 = 30 – 35 years; 3 = 36 – 40years and 4= 40 years and above.
- *Marital status* was dichotomised into: 1 = Married and 2 = Single/divorce/widowed.
- *Level of education* was dichotomised: 1= Primary & Secondary School and 2 = Post-School/Tertiary/Diploma.
- *English Language proficiency* was coded into 1= write and speak English, 2 = Understand English, 3= No English. It was later dichotomised to distinguish the group of respondents who had no English from those that had some level of English proficiency: 1 and 2 = Some English =1 and No English = 0.
- *Socio-economic status* was recoded into: 1= Not having enough money for basic things such as food or clothes, 2 = Having enough money to buy basic things such as food or clothes and able to buy expensive things (1 person only).

Construction of Measures

Three household resources measures were created that were aligned to the theoretical framework, namely Material Resources, Investment Potential Resources and Social Resources by summing the relevant items (See Table 6 for items). Due to the response rate of Social and Investment Potential Resources, these measures were dichotomised (See table 9). For Social Resources, 0 = 1 while scores 2 and 3 = 2; Investment potential 0 and 1 = 1 and 2 and 3 = 2. A total score for all the household resources were created by summing all the latter resource items.

In addition, a Social Capital (bridging) measure was created by summing the items related to social network support. Recoding was conducted namely for scores 2 and 3 =1, 4 become 2 and 5 was recoded to 3.

Satisfaction with consultation encounter: Two indexes namely a clinic consultation satisfaction index (CCSI) and a doctor consultation satisfaction index (DCSI) were created by summing the relevant items for the different settings (see table 9). The descriptive statistics for the measures computed are depicted in table 10.

Statistical tests conducted

The Chi-square (χ^2) tests were used to explore relationships among categorical variables. It was used to explore 1) the relationship between demographic variables (level of education, gender and age) and satisfaction of health care provided and socio-economic status of caregivers, 2) the relationship between demographic variables (level of education, gender and age) and the different resources adopted in the research framework (i.e. material

resource (MR), Investment Potential (IP) and Social Resources (SR)) as well as social networks of refugees caregivers.

The Mann-Whitney U test were used to test for differences between two independent groups, i.e. demographic data in relationship with satisfaction with healthcare services to both public and privet facilities. It was also used to evaluate differences regarding caregiver's experience with healthcare system.

Kruskall-Wallis, test was done, to test significant different among caregivers social network with their healthcare satisfaction see table 9.

3.7.2 Qualitative data analysis

For the qualitative study, the data processing and data analysis are addressed.

The data was translated and transcribed verbatim from French into English. Thematic analysis was used to analyse the data using the guidelines of Braun and Clark (2006). The first step in analysing the data for this study involved familiarizing and immersing oneself in the data to identify the common themes (Ulin et al., 2002). In the second step, themes were identified that shared the same words, styles and terms that were used by participants and ways in which they were connected. This was followed by coding of the themes and sub-themes linked to the broad objectives of the study that was to provide a deeper understanding of the issues obtained in the quantitative research study. The last step in the process involved the interpretation of the data and cross checking it to the data (Terre Blanche et al., 2006).

3.8 Validity and Reliability of study findings

The validity and reliability of the study findings are supported by the explanatory mixed method design that was used for the study in which the quantitative findings were verified and further explored in the qualitative study. Specific attention was also paid to support validity and reliability of the quantitative and qualitative studies.

Quantitative study

Reliability is a concept used for testing or evaluating quantitative research, which is used in the most of research, testing of quality in a quantitative research is one of the ways of information elicitation (Patton, 2002). The quantitative questionnaire was developed based on a good understanding of the literature, the theoretical framework and the aims and objectives of the study. Items from the National Survey of Early Childhood Health (NSECH) used in the study of Halfon et al. (2004) pertaining to the satisfaction with health care for young children were included as those were used in international studies with adequate empirical evidence but not in South Africa though.

Qualitative study:

A good qualitative study can help us to understand a situation that would otherwise be confusing (Nieuwenhuis, 2007).

Validity

Validity is a necessary nature usually used for flexibility and open-endedness in a qualitative research method (Nueman, 2011). Validity in a qualitative study helps to determine the accurateness of the research findings from the researchers' participants and readers 'point of view (Creswell, 2005). The researcher incorporated the following validity strategies) into the

research. Findings of the study were conveyed using rich “thick descriptions”. Providing a detailed description of the setting or providing many perspectives about a theme makes the results more realistic and richer thus adding to the validity of the findings (Creswell, 2005). To increase the accuracy of the study the researcher also used peer debriefing. A peer who had a general understanding of the nature of the study was given a chance to review and ask questions about the study. This strategy which involves an interpretation beyond the research and invested in another person adds validity to an account (Creswell, 2005).

Reliability

Reliability in qualitative indicates the consistency of the research approach across various researchers and various projects. Reliability is considered an important aspect in quantitative data collection, whereas qualitative researchers are less concerned about it (Willing, 2008). To ensure reliability of the study the researcher thoroughly checked the transcripts so as to make sure that no mistakes were made during transcription (Creswell, 2005). A detailed account of the data collection and analysis process was also done by the researcher so as to provide the readers a precise and unambiguous picture of the methods used in the study. It has been argued that there is a need for researchers using the qualitative approach to write down the procedures of their case studies and to document as many of the steps of the procedures as possible (Creswell, 2005)

Transferability

According to Babbie and Mouton (2010, p. 277), transferability refers to the extent to which research findings can be applied or generalized in other contexts or with other respondents. Qualitative researchers are however not interested in statistical generalizing (Babbie and Mouton, 2010), but are interested in gaining a deeper and better understanding of specific

phenomena. Transferability in qualitative research thus rests on similarities between sending and receiving contexts, the researcher gives detailed descriptions of data so as to allow judgements about transferability to be made by the reader (Babbie & Mouton 2010).

CHAPTER FOUR

RESULTS

4.1. Introduction

This chapter presents both the quantitative and the qualitative results. The first section describes the general characteristic of the study sample. This is followed by the results pertaining to the participant's socio-economic status and social support and network of refugees. The perceived general health care status of refugee children and care giver's health care seeking behaviours are then discussed.The final section addresses the general satisfaction with health care services rendered to their children and in particular the factors that are linked to care giver's level of satisfaction. The qualitative findings were integrated into the quantitative findings where appropriate to elaborate in more detail on the quantitative findings.

4.2 Socio-demographic characteristics of the participants

The demographic characteristics of the participants are presented in Table 1. Eighty-nine percent (89%) of the participants were females with the remaining 11% being males. About 60.8% of the respondents were aged 30-35 years, and 17.5% and 11.7% of the participants were in the age groups of 23-29 years and 36-40 years respectively. The majority of the participants (80.0%) were married, and 90% were actual caregivers of their own children. Approximately 71% of the respondents in the study had senior secondary education, and 90% were Christians, with the remaining 10% been Muslims. The results as presented in Table 1, shows that the majority (70.8%) if the participants had three children, whilst 23.3% had four to five children and 5.9% having six to seven children.

Table 1: Socio-demographic information of the participants (N= 120)

Characteristics	Number	%
Gender		
Male	13	10.8
Female	107	89.2
Age groups		
23 – 29 years	21	17.5
30 – 35 years	73	60.8
36-40 years	14	11.7
>40 years	12	10.0
Marital status		
Married	96	80.0
Separated	17	14.2
Divorce	6	5.0
Widower	1	0.8
Relationship with child		
Mothers	108	90.0
Fathers	12	10.0
Number of children		
3 children	85	70.8
4–5 children	28	23.3
6–7 children	7	5.9
Caregiver's level of education		
Primary school (Grade 1 – 6)	5	4.2
Junior secondary school (Grade 7– 9)	22	18.3
Senior Certificate (Grade 12)	85	70.8
Tertiary	8	6.7
Religious Affiliation		
Christian	108	90.0
Muslim	12	10.0
English language proficiency		
Write and speak English	31	25.8
Understand but cannot speak	33	27.5
Neither speak, understand nor write	56	46.7
Reasons for locating in Durban		
Had relatives living in Durban	61	50.8
Came through Mozambique and stayed	46	38.4
Job opportunities	7	5.8
Clean city	3	2.5
Feel secure in Durban	3	2.5

It was observed that 92.3% of the 13 men in the sample had a post-school qualification while 74.5% of the 106 women had a post school qualification (Diploma and Tertiary level

education). Similarly, for age group, the majority (63.7%) of participants aged between 30–35 years reported having a post-school qualification.

About 46.7% of the participants in the study were not able to communicate in English (i.e. could not speak, understand or write in English), while 27.5% reported than they understand but cannot speak English and about a quarter (25.8%) revealed that they could speak and write in English. A Chi-square test showed that the participants who are proficient in English are also those who have a higher level of education ($\chi 2 = 4.08$, $df = 1$; Fisher's exact test $p = 0.049$). Almost all (98.2%) of the participants who could not speak, understand or write in English, were female.

With regards to their documentation, the majority of the participants (86.7%) were asylum seekers (i.e. not classified as refugees by the UNHCR), while 13.3% were officially refugees. However, a few participants (4.2%) indicated at a later stage of the questionnaire that they do not have any valid documentation to be in South Africa, a reason offered why they are unable to access health care services for their children.

About half of the refugee caregivers decided to locate in Durban as they already had relatives living in Durban. A substantial group (38.5%) indicated that because they entered South Africa through Mozambique, they felt safe and decided to stay in Durban.

4.3 Socio-economic and social-support of participants

The socio-economic conditions, household resources and available social capital information are presented in Table 2. With regards to the economic challenges refugees face, the majority of the participants (66.7%) reported that they don't have enough money for basic things like food and clothes, with only 0.8% of the respondents indicating that they have money to afford more expensive items such as a TV, radios etc. but not enough money to buy any expensive commodities.

Participants, who reported having enough money for food and clothes, were also more likely to report having a post-school qualification. (χ^2 = 4.406, *df* = 1; Fisher's exact test p =0.42). Interestingly, further analysis did not reveal any significant difference between those who had money for basic food and clothes and those that had enough for the basics and their English language proficiency (χ^2 = 1.070, *df* = 2; Fisher's exact test *p* = 0.589).

When participants were asked about their source of income, the majority of the respondents (96.7%) reported that they were not fully employed. Most 85% rely on family/friends members and 75.8% received help from their church (pastors). Additionally, 53.3% of the participants indicted they rely on their own skills to get an income by providing some needed services to the refugee community

4.3.1 Household resources

The household resources were assessed in terms of material resources, social resources and investment potential in reference to the household resource theory. In table 2 the frequencies for the individual items of the measurement indexes are depicted while table 3 depicts the scores of the composite indexes. Very few obtained the maximum scores on the measures. With regards to material resources, 26% of the respondents had some material resources, 42.2% reported to have social resources and the majority of the respondents reported to have investment potential (58.2%) (See Table 2).

Table 2: Frequencies of items regarding household resources and social capital

Items linked to the Household Resources	N	Yes %	No %
Material Resource items			
Working full time	120	3.3	96.7
Work Part time	120	12.5	87.5
Sell some of my possessions to get money	120	5.8	94.2
Have enough money for basics like food and clothes	120	33.3	66.7
Social Resource items			
Getting financial help from family/friends in SA	120	85	15
Getting financial help from church/pastor	120	75.8	24.2
Getting money from family/friends in the DRC?	120	0	100
Investment Potential Resources			
Trading	119	88.2	11.8
Have many unused skills	111	100	0.0
Using skills to provide services to refugee community	120	53.3	46.7
Social Capital items (bridging)			
Know people who can help	120	97.5	2.5
Know people who are well connected with others	120	100	0.0
Know people who are willing to help when there is a need	119	72.3	27.7
Give assistance to other refugees	120	70.8	29.2
Received assistance from my community	120	64.2	35.8
Social Capital items (linking)		N	%
Have made contact with UNHCR			
Yes		9	07.5
No		111	92.5
If Yes: Reason for the visit (n=9)			
Social support		3	33.3
Refugee documentation		4	44.4
Information to relocate back home		2	22.2
Ever visited an office of an NGO working with refugees			
Yes		93	77.5
No		27	22.5
Received help from NGOs			
Received no assistance		48	51.6
Paid rent for few months		19	20.4
Received food vouchers when first arrived in SA		17	18.3
Paid school fees		9	9.7

The Chi-square tests that were conducted to assess whether level of education and English language proficiency impacted on available household resources, showed that all test were

not statistically significant. The chi-square tests showed no statistical significant relationship between the social capital index and all the household resource measures.

4.3.2 Social networks

Social networks can also be considered to be an important household resource as social networks plays a central role in psychosocial and physical wellbeing of refugees. Therefore the social connections between people assist in support and sharing of information.

The results in Table 2 also revealed that the majority of the respondents also relied on social networks for help. Ninety-seven percent of the participants know someone who could help, 72.2% are aware of people who are willing to help whenever there is a need, while all the participants were aware of people who are well connected with others. The **social network index** showed that most of care givers had access to social networks as depicted in table 3 (80.7%).

The chi-square tests showed that gender, age and English language proficiency groups did not differ significantly with regards to social networks. However, those care givers with a higher level of education had higher levels of social networks (χ^2 = 6.962, *df*= 2, p = 0.031, *phi* = .243; CI=0.074-0.439) than others. According to Cohen's (1988) criteria, the difference was however small

With regards to social networks outside of the refugee community, very few participants (7.5%, N=9) indicated that they had visited the United National High Commissioner for Refugees (UNHCR) for support. The key issues that they sought help for included social support (33.3% N=3), refugee documentation (44.3% N=4) and advice on the relocation back to their country of origin (22.2% N=2). The results also showed that refugees received help from Non-governmental Organisations (NGO's). However 51.6% indicated that they never received any assistance while those who received assistance, were supported to pay

rent (20.4%) and some indicated that they were given food vouchers when they first arrived in South Africa (18.3%). The remaining 9.7% reported receiving help with regards to the payment of school fees.

Total available household resources

With regards to the Total Resource Index (summing of available resources), the Independent samples t-test results suggested that females and males differ significantly on this measure with females (M = 2.12, SD = .67) having a higher mean score than males (M = 1.67, SD =.78; $t(108) = 2.164$, p =.033). The magnitude of the difference in the means was small, Eta^2 = 0.04). It was also found that respondents who did not have any English proficiency (M = 1.83; SD = .80) differed significantly from those who have English proficiency (M =2.16, SD = .64; $t(108) = 2.238$, p = .027). The participants with English proficiency seemed to have more available resources. The effect size was also small, Eta^2 = 0.04. The frequency and values from which the above result was derived are presented in Table 3 below

Table 3: Frequencies of household resource measures

Scores	N	%
Material Resources		
0= Very limited	63	52.5
1 = Limited	48	40.0
2 = Basic	9	7.50
Social Resources		
0 = Very limited	78	65.0
1 = Limited	37	30.8
2 = Basic	5	4.2
Investment Potential		
0 = Very limited	11	10.0
1 = Basic	35	31.8
2 = Potential	55	50.0
3 = Adequate Potential	9	8.2
Social Networks*		
2 = Limited	1	0.8
3 = Basic	23	18.5
4 = Adequate	66	55.5
5 = Well connected	30	25.2

* Recoded for analysis

Qualitative Findings

The qualitative findings highlighted the inconsistency in support rendered to the refugee community and the limited support they actually receive. There seems to be the view that they are discriminated against as a female caregiver described:

> With regards to the Refugee Social Services, I can say it doesn't help, because they [provision of services] are based on discrimination, just like the nurses do at the clinics. If you don't have a friend(s) who are working in their offices, you won't get help. However, I have heard from some of my friends that they received help from them, where they paid two (2) month's rent for them and also gave them food. (Female, participant 3)

4.4 Child Health Status and Immunization

The refugee care givers reported to have not received any health screening in the form of a medical examination or a mental health assessment when they first arrived in South Africa. When asked about the health status of their children, the majority (79.2%) of the caregivers revealed that their children are generally healthy. However, 22.5% of caregivers indicated that they previously had lost a child through illness. With regards to the importance of immunization, the majority (66.7%) of the participants understood that immunization protects children from diseases, 19.2% said that it has a "neutralizing effect" on diseases while 14.2% indicated that they do not know.

Participants' responses regarding childhood immunization of their children are shown in Table 4. All the children completed the immunization process up to the ages of 18 months. Follow-up immunization at 6 and 12 years are incomplete. However, the majority of children (72.5%) received the Td booster (Tetanus and reduced strength diphtheria vaccine)

at 6 years of age and only a small group (N=28, 23.3%) received the final booster at age 12. It should however be noted that the majority of children (82%) in the study were younger than 12 years and is likely to received it later. The results further showed that the majority of the children (70%) were immunized in the Democratic Republic of Congo, while the remaining 30% were immunized in South Africa.

Table 4: Summary of child immunization

Name of vaccination child received and age when it was done	N	%
BCG/TOPV at birth (Bacillus Calmette Guerin (Anti-tuberculosis vac	120	100
TOPV RV DTP-IPV/Hib Hepatitis B PCV7 at 6 weeks,	120	100
DTP-IPV/Hib Hepatitis B at 10 weeks	120	100
RV DTP-IPV/Hib Hepatitis B/ PCV7at 14 weeks	120	100
Measles at 9 months	120	100
DTP-IPV/Hib /Measles at 18^{th} months (repeat)	120	100
Td at 6 years (both boys and girls)	87	72.5
Td repeat 12 years (both boys and girls)	28	23.3

4.5 Health care seeking for children

The responses of caregivers regarding health care seeking for children are shown in Table 5. In general, the majority of the participants (74.2%) indicated that they primarily seek health care from the public health care clinics (which are generally free of charge), 23.3% from the hospital (23.3%) and the remaining 2.5% seek health care from private medical practitioners. Participants who use private medical practitioners indicated that they prefer them primarily because of the higher quality of healthcare received from them. Those to sought help from private doctors reported that 52% were Congolese, 8.3% from other African countries, 38.3% Indian doctors and 1.7% others.

4.6 Action taken when children are ill

The majority of the participants (80.8%) indicated that the last time their children were sick, they visited the local primary health care clinic, visited the pharmacy (8.3%), prayed for

their children to get better (7.5%), and sought advice from their friends or neighbours (3.3%). There were delays in seeking formal health care by the caregivers as 57.5% waited longer than 4 days before they sought help. Some sought formal health care within a day (30.8%) and others within two to three days (11.7%).

Table 5: Health Care seeking behaviour descriptions

Health care seeking items	N	%
Health care facilities normally visited for ill health (N=120)		
Public clinic	89	74.2
Public hospital	28	23.3
Private Doctor	3	2.5
Actions taken after unsuccessful treatment at public facilities(N=120)		
Seek help from private hospital	74	61.7
Go to another clinic	26	21.6
Get medicine from the pharmacy	9	7.5
Prayer	11	9.2
Actions taken recently when child was ill (N=120)		
Went to local clinic	97	80.8
Bought medicine at the pharmacy	10	8.4
Prayed to God	9	7.5
Ask friends/neighbours for advise	4	3.3
Normal waiting time before seeking medical care (N=120)		
No delay – same day	14	11.7
After 1 day	23	19.2
After 2 to 3 days	14	11.7
Four days and longer	69	57.4
Reasons for the delay of four days and longer (N=69)		
Unable to speak English or Zulu	43	62.3
Health care workers hold negative attitudes towards refugees	21	30.4
Do not have valid documentation to stay in South Africa	2	2.9
Other reasons	3	4.4
Information/advice received about health issues [a]		
Friends	53	44.2
Neighbours	78	65.0
People at church	47	39.2
Health clinic	120	100
Private doctors	62	51.7

[a]*Multiple responses to the variable, therefore % are more than 100*

Key reasons caregivers gave for the four days and longer delay were their inability to communicate in English and isiZulu (62.3%) and the negative attitudes of health care

workers towards refugees (30.4%). About 7.2% of the caregivers attributed the delay in health seeking to a lack of valid documentations for staying in South Africa.

When participants were asked about their means of transportation to health care centers, 65.0% indicated that they use public transport, while the remaining 35% walked. For participants using public transport, the average transport ranges from 10ZAR to 20 ZAR ($0.73 to $1.47; US Dollars) considered by most as expensive, when not having enough money for food.

4.7 Satisfaction with health care service delivery

The caregivers were asked to rate their level of satisfaction with both public health clinics and private doctors over the last six months on a 11-point scale (0 = not satisfied at all to 10 = highly satisfied). The results on the satisfaction of the health care service delivered to their children showed that most of the care givers were dissatisfied with the quality of health care rendered to their children, particularly when referring to public health care services. Very low ratings were noted for the public facilities a rating of zero were given by 11.7%; a rating of one by 45% and a rating of two by 43.3%. However, private doctors received ratings of five by 3.3%; a rating of six by 21.7%, a rating of seven 34.2% and a rating of eight by 40.8%. While asked about, it seemed that the services of faith healers, herbalists and traditional healers were not sought and therefore not rated.

The descriptive statistics for these measures are shown in table 6 below. It is clear that the response options on the rating scale for care giver's satisfaction with public clinics were very restrictive and at the lower end of the rating scale ranging from 0 to 10, showing mainly dissatisfaction with the clinic health services.

Table 6: Descriptive statistics for satisfaction measures regarding public and private health care services and total household resources

Health Facilities	N	Min/Max	Range	Md	M	Std	Skewness
Public Clinics	120	0/10	3	2.0	2.32	.673	-.478
Private Doctors	120	0/10	3	8.0	8.13	.865	-.562
Clinic Visit Index	118	0/6	2	0.0	0.37	.536	1.034
Doctor Visit Index	114	0/6	3	6.0	5.38	.780	-.891
Total Resources	109	0/15	3	7.0	6.64	.944	-.059

The frequency distributions for satisfaction of different service aspects of the last child health care consultation are depicted in table 7 below.

Table 7: Frequencies of health care services experiences during the last child health care consultation

Experiences during last clinic visit	Yes N (%)	No N (%)
Public clinics		
Were you able to ask all the questions you wanted to?	9 (7.5)	109 (90.8)
Did the nurse provide you with enough information?	10 (8.3)	110 (91.7)
Did the nurse spent enough time with your child?	1 (8)	119 (99.2)
Will you recommend the clinic to others?	26 (21.7)	94 (78.3)
Did you have to wait too long before being attended to?	120 (100)	00
Did the nurse respect your views about your child's health care needs?	00	120 (100)
Private doctor		
Were you able to ask all the questions you wanted to?	85 (70.8)	35 (29.2)
Did the doctor provide you with enough information?	102 (85)	15 (12.5)
Did the doctor spent enough time with your child?	120 (100)	00
Will you recommend the doctor to others?	120 (100)	00
Did you have to wait too long before being attended to?	00	120 (100)
Did the doctor respect your views about your child's health care needs?	108 (90)	6 (5)

4.8 Distribution of health care service experiences during the last child health care visit

Participants were asked to evaluate their level of satisfaction with the last health service consultation regarding their children at the public health care clinic and private doctor using a yes and no response format. This information as presented in Table 7 clearly shows that the care givers were more negative on most aspects of the last consultation at the public

clinics when compared to that received by private doctors. With regards to the clinic service, most felt that they were not able to ask the questions they wanted to (90.8%; n=109); that not enough information were provided to them (91.7%; n =110); not enough time was spend with their children (99.2%; n = 119) and that their views about their children were not respected (100%). However, these views were more positive for private doctors. Most indicated that they were able to ask the questions they wanted (70.8%, n = 85); that the doctors provided enough information (85%, n=102) and that doctors respected their views 90% (n = 108).

Health encounter satisfaction indexes for both private doctors and public clinic visits were constructed by summing the items pertaining to the different aspects of the consultation process as depicted in the frequency table above.

The Mann-Whitney U test (table 8 below) conducted on both the satisfaction rating scales did not show any significant differences between gender and level of education (lower and higher levels While not depicted in table 8, it should be noted that caregiver's level of education (Post-school versus School) and SES (Not enough for basics versus enough for basics) showed no significant difference in satisfaction with health care services.

Table 8: Demographic differences in terms of satisfaction with health care services

Demographic	**U**	***z***	***p***	**Median**	**Median**	**r[b]**
				Males	Females	
Public Clinics	558.500	-1.273	.203	2.00	2.00	0.12
Private Doctors	537.500	-1.421	155	9.00	8.00	0.13
Clinic Index	531.000	-1.569	.820	.00	.00	0.14
Doctor Index	628.000	-.754	.777	6.00	.6.00	0.10
				Higher Edu		Lower Edu
Public Clinics	1242.500	-.217	.828	2.00	3.00	0.03
Private Doctors	1166.000	-.721	.471	8.00	8.00	0.05
Clinic Index	1119.000	-.508	.612	.00	.00	0.05
Doctor Index	995.500	-.807	.420	6.00	5.00	0.08

[a] Mann-Whitney U test ($p \leq 0.05$);
[b] Cohen's Criteria: 0.1=small effect; 0.3=medium effect; 0.5=large effect.

4.9 Satisfaction with health care services in terms of household resources

Mann Whitney U tests were conducted to access whether significant differences exist between group with different levels of household resources pertaining to their level of satisfaction with health care services. The tests did not show any significant differences between social resources (SR) and material resources (MR). The groups performed equally irrespective of the available household resources. Those with no investment potential (IP) resources had higher median scores on the satisfaction rating scales. See Table 9 below.

Table 9: Mann-Whitney U-Test results for differences in health care satisfaction among groups with different resources

Social resources factors [a]	U	*z*	*p*	Median	Median	r[b]
				Social RS	No Social RS	
Public Clinics	1571.000	-406	.685	2.00	8.00	0.04
Private Doctors	1609.000	-170	.865	.35	2.00	0.02
				MR	No MR	
Public Clinics	1286.000	-.520	.603	00	2.00	0.05
Private Doctors	1198.500	-1.066	.286	2.00	6.00	0.10
				IP R	No IP R	
Public Clinics	380.000	-2.238	.025	00	2.00	0.21
Private Doctors	301.000	-2.976	.003	2.00	6.00	0.30

[a] Mann-Whitney U test ($p \leq 0.05$);
[b] Cohen's Criteria: 0.1=small effect; 0.3=medium effect; 0.5=large effect.

The results of the Kruskall-Wallis tests, in table 10 below show that caregivers with no English proficiency had a higher median score on the satisfaction rating scale on clinic services. No significant differences were detected on the satisfaction rating scale for private doctors and satisfaction of consultations for private doctors and clinic services. The non-significant differences are not shown in the table below

Table 10 shows significant differences among the care givers' social networks and their satisfaction with the public sector clinics and private doctor consultation satisfaction. Those with larger social networks obtained a higher median score on the satisfaction regarding

public clinic services rating scale than the other groups. For the doctor satisfaction index, those with medium sized networks scored a higher median on the satisfaction index. Similarly, the medium sized network group scored significantly different from the other two groups on the doctor satisfaction index. The non-significant differences are not shown in the table below.

Table 10: Satisfaction with health care services re social networks and English language proficiency

Satisfaction Measures	N	X^2 (df=2)	*p*	Median[b]		
English Language Proficiency				**English(n)**	**Understand(n)**	**None (n)**
Clinic Sat.	120	5.71	<0.001[a]	2(31)	2(33)	3(56)
Social networks				**Smaller(n)**	**Medium(n)**	**Larger(n)**
Clinic Sat.	119	13.01	<0.001[a]	2(23)	2(66)	3(30)
Doctor Ind.	113	7.73	<0.021[a]	6(23)	5(63)	6(27)

[a] Significant results of Kruskall-Wallis tests ($p \leq .05$); [b] Range 1 to 3

Qualitative Findings

The qualitative findings support the quantitative results in the sense that dissatisfaction with the public health sector was reiterated. However, greater clarity was given to understand the issues that are problematic. The findings suggested that the participants' dissatisfaction with health care services were due to a range of issues that include structural limitations and discriminatory attitudes towards refugees. With regard to structural impediments, the participants talked about the long waiting times before being attended to by health care workers:

> For my first time I was with my husband it was terrible, we stood for more than 4 hours since 6 am to 9am - the queue was so long. After 8am they gave us numbers. We were seen by the healthcare workers after being tired, the nurse who received my child was nice, he was so cool and polite, but the one who was taking measurements

was complicated - she was not talking to me. On the appointment days for immunization, we are facing hard times at the clinic. Some nurses - they don't treat foreigners like people who don't have a country, they talk any way - they insult people and all their healthcare education is done in Zulu - if you ask, they don't respond to your question, but if their own people ask, they respond nicely. (Female, participant 2)

No, I never feel happy, at the local clinic there are many things that can make you not feeling happy. You have to be there all day from 6 am until the end of the day, and at the end, they will give you just Panado, and also, you spend all your time and you worry about what the family will eat. On the clinic day of my children, I used to cry, because I will have a double lost. (Female, participant 4)

Furthermore, the qualitative findings revealed that nurses' attitudes in the public hospitals as well as the good services from private practitioners compel them to use private hospitals than public.

There is big difference between these two clinics [i.e public and private]. At the private clinic, patients feel at home and they feel more comfortable, not only because we pay the money but the way healthcare workers treat you and you feel half treated before you receive any medication. They welcome a patient so nicely and they take time asking you questions. Back home, in DRC, patients don't have to wait for a long period like they do in these local clinics. When you meet with a doctor he takes time and ask you all questions and he explains to you - something which is totally different from the local clinics where they don't give you time to ask what is wrong with you. In the private clinics, they would tell you in the nice manner if you need

> some specialist and you feel okay even if you are sick, and they show you love. They don't have a discriminatory attitude like at the public clinic where nurses tell you "rubbish". I am so disappointed with healthcare services at the public clinic.

> When I was at home in DRC, I was talking to my friends here about my child who used to suffer from renal problems. They told us in South Africa, healthcare services are high [excellent] but when I arrived here, my big purpose was about my child - but my bad luck was that my child died. When I took her to the clinic with one of my friends, I felt abandoned by healthcare workers. I spent more than 6 hours at the clinic, and no nurse cared to talk to me. It was only after my friend complained that they took the temperature [of my child] and we waited again for another 2 hours before we were able to see the medical doctor. The doctor gave me an appointment to see him again in 4 days' time, and then the child died before the appointment day. From that day onwards, I have a bad image of nurses at local clinic (Female participant number 1).

Some of the participants also indicated that notwithstanding the bad attitudes of nurses towards refugees in general, they prefer public clinics because of proximity and the fact that the service is free.

> I chose this clinic [public clinic] because it is for free and also it is close to my place. But I don't like it due to many challenges we are facing at the local clinic. Nurses treat people like "animals" at the clinic. If you meet the bad or not well behaved nurse that day at the clinic, you feel like not coming back again - but there are others days when you meet with a good nurse. I cannot choose to go to the private doctor because I don't have money, especially for children whose healthcare services are

very expensive. They are so expensive at the private clinics. I have been at the private clinics myself before, so I know how expensive it is - but the services are well organized and good quality (Female, participant 5)

4.10 Conclusion

The results indicated that refugees face socio-economic challenges despite their relatively high level of education. Dissatisfaction with the public health services was reported which was not clearly differentiated in terms of socio-demographic variables indicating a generalised dissatisfaction among the refugee care givers with public health care clinic services. However, the qualitative findings do suggest that there are nurses in the public health care sector that are caring and offer a good service.

In the next chapter, the results will be discussed in terms of the available literature and theoretical framework.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter discusses the main findings of the study. The individual and household characteristics that include the socio-demographic information, the socio-economic status i.e. material resources, investment potential and social resources that encapsulate social networks will be discussed first. This will be followed by the views on geographical accessibility of health care services, availability of services linked to their perceived child health care needs, and lastly views about health care acceptability that include their views of the health service and level of satisfaction with health care delivered to their children. Thereafter a conclusion will be followed by recommendations.

5.2 Individual and Household characteristics of caregivers

As mentioned above, in this section the individual aspects that will be discuss include demographic information about the caregivers, the health status of their children and health seeking behaviour. In terms of the household characteristics the socio-economic status of the caregivers linked to household resources i.e. material, investment potential and social resources that include both formal and informal social networks and support.

5.2.1 Individual Demographical Characteristics of caregivers

The majority of respondents in this study were in their reproductive years i.e. between 31 to 35 years old. This finding is congruent with a newspaper article some time ago in the Mail and Guardian that reported on the South African National Survey among refugees and asylum seekers and found the average age of exiles to be 31 years (Mail & Guardian 2003).

The results confirm than young individuals are mobile and able to migrate easily during difficult times but because of their children also likely to take greater risks of travelling and seeking refuge, in many instances without proper documents (Human Rights Watch, 2010). Also in contexts of armed conflict, this age group could be more targeted as they might pose greater resistance to rebel movements (Wood, 2010).

Most of the caregivers were *women* as the main responsibility of caregiving within traditional families and within African contexts falls on women (Steyn & Viljoen, 2014). Apart from their household responsibility and caring for their children, they also play an important role in the decision making process regarding their children's health (Steyn & Viljoen, 2014). Men's role on the other hand is to ensure their livelihood through financial ways (Steyn & Viljoen, 2014). The few male caregivers in the sample are therefore contrary of the general norm for African men as carers (REF). However, norms are also changing for men and women where child care has become a more a joint responsibility even within African contexts (Montgomery, 2006).

It is also likely that the *lack of job opportunities* for women in general, limits the possibility of them seeking or obtaining employment. The majority of women had a senior certificate qualification (Grade 12) with only a few having a tertiary qualification. On the other hand, the male caregivers reported to have a post-school qualification. This is also suggestive of the gender inequality in education opportunities that exist in African countries and elsewhere where the education of the girl child does not enjoy the same priority than that of boys (UNICEF, 2015).

In an early study among migrant traders in Durban, women were found to be underrepresented while South African traders were predominantly women (Hunter &

Skinner, 2002). Refugee women with little disposable income are unlikely to be able to pay for a child caregiver in order to secure employment.

The data also show that the majority of caregivers had three to four children with a few having up to seven children, which will make it also difficult to seek employment. Family planning and reproductive health care should be a priority among refugee communities especially in light of their general low socio-economic status among refugees (Ramsden& Marsh, 2014) and challenges in finding employment (Swartz, 2009). While all caregiver were from the Christian faith, some indicated belonging to the Roman Catholic denomination, and could be a possible explanation of the high number of children in some families as reliable medical contraceptives are not encouraged (Agadjanian, 2013).

The employment opportunities of caregivers, females in particular, are further compromised by their low levels of proficiency in English as the national language of the DRC is French. English is one of the national languages in South Africa and generally seen as the language of work. The inability to speak English is not only impeding their ability to find employment but will also impact negatively on their full integration into the South African society as suggested by Heugh (2000). Furthermore, the ability to speak the language of the host country has been argued to reduce anxiety and thereby enhances greater psychological wellbeing among refugees (Krumm, 2012).The barriers of language plays out in different ways as the study results suggest and impact negatively on health care accessibility and levels of satisfaction with health care services that will be discussed in more detail in the sections below.

5.2.2 Household resources

The *socio-economic status* among refugee is amongst the key challenges they face and contribute to their health and wellbeing vulnerability (Kirmayer et al., 2009; Swartz, 2009). The caregivers in the study reported on their very poor housing and living conditions, the overcrowding as families need to share the same accommodation and general poverty that they all experience. This seems to be common among many refugees all over the world (Smit, 2015). The link between poverty and ill health and mental distress is well established (Yoshikawa, Aber & Beardslee, 2012). The socio-economic status of refugees has been found to be one of the major barriers to accessing healthcare service and other support services in the host country (Payton, Patel, & Scott, 2015). The lack of financial resources is likely to impact negatively on health care access (Peters et al., 2008; Wallman & Baker, 1996).

Peters et al. (2008) argued that financial accessibility imply the cost of the services (either directly or indirectly), the ability to pay for the costs as well as the protection against the economic consequences of health costs in cases of illness. The material resources enable them to seek health care, pay for transport and medication if required or go to the pharmacy and buy medication. In the study, the material resources of the refugee caregivers were very limited. More than half of caregivers reported not having enough money for basic needs such as food or clothes. They have very limited material resources as most are unemployed and those that do have some form of income obtain this from part time work and trading. Anecdotal evidence suggest that many refugees work in the informal sector with little protection and work as car guards, as casual labourers in hair salons and even resort to trading in pirated movies (in attempts to keep their families alive.

As previously discussed, job opportunities are also restricted due to their limited proficiency in English. However, the males seemed to have a higher level of English proficiency than the female care givers. The lack of job opportunities for refugees should be viewed against the high unemployment rate of 25.5%in South Africa among its citizens (Stats SA, 2015). In addition, the affirmative action legislation may also impede the employment opportunities of foreign nationals despite the legal status of refugees (Brewer, 2015). In addition, the widespread xenophobia among many South Africans is also likely to limit income opportunities (Nkosi, 2014).

The caregivers indicated some investment potential i.e. their skills and capacity, but due to the various barriers mentioned they may not be able to convert this into material gains as outlined by Peters et al. (2008). This also implies a loss to the South African society as refugees with scarce skills could be utilised to the betterment of all.

However, access to healthcare services cannot only be considered within economic terms only due to its dynamic relationship with the various political, legal and social challenges that refugees experience in the new host countries (Bakker, Dagevos &Engbersen, 2014).

Refugee status

In this study it was clear that the *legal status of refugees* and their related documentation impacted on them accessing health care service. While most seemed to have asylum seeker or refugee status, a few reported having no documentation. The refugees in the study reported that unless they are able to produce their documentation they are not given health care. While refugees seem to interpret this as an extension of South African xenophobia, this should be seen against the background of limited human resources and constraining budgets

of the South African health departments. Health workers should also practice within the constraints of policies that govern free health care delivery to both citizens and foreign nationals (DoH, 2012). However, in cases of emergency, no health care can be denied to foreign nationals (DoH, 2012). Adequate attention should be given to equip health workers' delivering services to foreign nationals with adequate information as to the South African Constitution, and the Refugees Act (130 of 1998).

Social Resources: Formal social support

The lack of formal social support to refugees by governmental and non-governmental associations has been raised to impact their health as poor accommodation, lack of proper sanitation, overcrowding and poverty remain the major health related challenges they face. An office of the United National High Commission for Refugee in Durban has only been visited by a few of the caregivers to seek social support and some wanted to relocate back to their country of origin. It is not sure why they wanted to go back but it could be related to the xenophobia attacks that were experienced in Durban in the recent years (Ellison & de Wet, 2016). The caregivers also seem to think that little support can be expected from the office. A perception exists that the Refugee Social Service in Durban does not render a non-judgemental service, but perceive some level of discrimination and that few receive assistance. However, some respondents mentioned that they received some financial assistance to pay school fees. It is clear that the caregivers seem to expect more from these organisations what they are able to deliver.

Social Resources: Social support and networks

Informal support networks among the refugees seem to be very well developed and are the primary source of support to them. Assistance seems to come primarily from their church

community, friends and family. Social networks are important aspects that refugees use not only in selecting a country of destination but also in the host countries to survive, to gain access to information and services including health care services (Groot, 2004). About half the respondents indicated deciding on making Durban their home because of relatives that were already living in Durban.

Social network analysis has emphasized the importance of interpersonal networks that link people in ways that allow them to cope with everyday life and extraordinary circumstances and to link them with others who may have more information (Apalata et al., 2007; Martin, 2002; Taylor, 2009). Caregivers in the study indicated receiving financial and emotional support as well as information about the public health clinics and health from friends, neighbours and people at their church. These strong social networks among the refugee community can be viewed as cohesive communities of mutual support.

A study found that refugees relied heavily on informal social support from friends and family, and that this strongly influenced help-seeking including health care seeking (Simao & Nhambi, 2008). Advice is often sought from friends, family member and from community pharmacy before seeking help from private doctors or public clinics (Apalata et al., 2007). In the study, the majority sought help from the clinic but a small group (9%) first consulted with friends or neighbours when their child was ill.

The predominant support and reliance on the refugee community, with seemingly little networks and support from groups and organisations outside of the refugee community, maintain and continuously strengthen the social cohesion in the refugee community.

Health Status

Refugees and particularly those from conflict and war torn countries are viewed as particularly vulnerable for ill health and mental distress and are likely to require urgent and special care (WHO, 2010). Despite this general consensus, refugees and their children seeking safety in South do not seem to receive a physical and mental health assessment to determine their health condition and needs. This is different from many other countries where refugees and asylum seeker undergo a thorough medical assessment after they have settled in the host country to address their short and long term physical and mental health outcomes as well as to determine whether they need health and wellbeing monitoring (Kirmayer et al., 2011; Renzaho, Bilal & Marks 2014). As children in particular are viewed as the first casualties of displacement, violence and emergencies (Schauer, 2008), the health care needs of children should be a priority for health care workers and parents/caregivers. It was reassuring that all children's immunisations were up to date with only the boosters at age 12 outstanding. All the caregivers indicated that their children were immunised and the clinic cards were used to verify this. It seems that many children were immunised in the DRC despite the reported poor immunisation coverage in the country plagued by armed conflict with resulting disrupted infrastructure (Wang et al., 2014). The caregivers also showed some understanding into immunisation and the role it plays in the prevention of diseases. It must be noted that a relatively large number (22.5%) of the caregivers has lost their children from other illnesses, which could have been a results of the non-adherence to the immunization process in DRC or to diarrhoea, a common illness among children in developing countries. It has been revealed that the DRC is the second country after Nigeria with high infant mortality rate in sub-Saharan Africa (Mapatano et al. 2008)

5.3 Geographic accessibility of health care services

From the data it is clear that the public clinics can be considered to the accessible and most participants reported being in walking distance from the clinics and where transport is required, the costs seems reasonable. However, the limited financial resources available in refugee households might pose a barrier to access health care because of transport costs despite the fact that public health care services are financially accessible and free of charge. The South African Primary Health Care System offers a free public health care services to those that cannot afford to pay for health services (DoH, 2012)

5.4 Availability of health care services

In accordance to Peters et al. (2008), availability refer to the appropriate care available to those in need of care with consideration of the opening hours, the type of service delivered and materials available. In this regard the caregivers complained the long waiting times for health care services and perceived this as a major problem and also to waiting for many hours to receive painkillers. These views are likely to contribute to the overall dissatisfaction with the health care service and quality of care delivered. Bhatia (2007) reported that in situations where clients have to wait longer than an hour for health care service this could impact negatively on their beliefs about the quality of the service because of the emotional reactions such as stress and anger. The caregivers raised their frustration in the interviews of wasting a full day by waiting to be seen by a health care worker and being aware that they had other household responsibilities such as preparing meals and also care for their other children also supported by Clough et al. (2013). For fulltime caregivers it seems that spending a full day away from home result in anxiety and anger as suggested by Bhatia (2007). This aspect has been reported to impede health care seeking behaviour by women in

particular (Kibiribiri et al., 2015). However, long waiting queues has been a general complaint of the South African public health care delivery system (Coovadia et al., 2009). The participants were of the opinion that a free health services in South Africa equates to a low quality of health service. The notion that a free health related service suggests a low quality of service had been recorded among South Africans and in particular in relation to the distribution of free condoms by the government. The public were of the view that these condoms were of a sub-standard because they were freely distributed (Health Systems Trust, 2014).

The *language barrier* due to the limited English proficiency levels among care giver can be considered a impacting negatively on health care service delivery. Apalata et al. (2007) argued that language barriers contribute to the failure of treating refugees for whom English is not their first language. Not only is it difficult for health care workers to render a good quality service if they are unable to communicate with the caregiver about the child (Benson et al., 2014; Wong & Lee, 2006; Zihindula et al., 2015), it is also frustrating for caregivers not to be able to raise their concerns and ask questions. The results clearly show that caregivers were dissatisfied with the consultation process as they were not able to ask the necessary questions and nor were clear guidelines and explanations given. Language differences have been reported to increase psychological distress (Meuter et al., 2015) and hinder timely health care seeking (Gerrish et al., 2004).

As the ability to communicate in a shared language is linked to satisfaction with health care services (Morales et al., 1999), the negative views held by caregivers of the health care delivery could partly stem from the lack of communication between client and health providers. This was also supported in a study by Apalata et al. (2007) among refugees in Durban where refugees reported negative views with service delivery in public hospitals

partly because of miscommunication and the absence of interpreters. In the absence of professional health interpreters, family members or friends able to speak some English is often co-opted to translate between client and health care worker. This also comes with a cost as the other person has to be available to assist the caregiver. As discussed earlier, this process is also fraught with difficulty and misinterpretation (Gany et al., 2013; Winkel et al., 2013, Gill et al., 2011; O'Donnell et al., 2007).

A strong call has been made over the years for the use of professional health interpreters in different parts of the world challenges with delivering a quality service to migrant, asylum seeking and refugees (Bhui et al., 2003; Burnett & Peel, 2003; Gerrish et al., 2004, O'Donnell et al., 2007). Public health clinics that service refugee communities should consider seeking the service of either professional interpreters or alternately training members of the refugee community that has some background in health.

While not investigated, it is also likely that health care workers do experience frustration for not being able to communicate clearly to their clients. This frustration might be misinterpreted as negative, discriminatory attitudes towards refugees and even xenophobia by refugee clients. However, in the qualitative study the view was expressed that negative attitudes of nurses in particular is not linked to language as a barrier, but rather xenophobia directed at refugees in general that will be discussed in more detail in the next section. A lack of studies among health workers' experiences in delivering health care to refugees in South Africa hinders a more balanced understanding of refugee health care delivery and Departments of health should be more open to allow for research in this regard.

5.5 Acceptability of health care services

Acceptability according to Peters et al. (2008) includes the users' attitudes and perceptions about the health care services and characteristics of the health care service. These are also influenced by the level of understanding refugees have of the new country's health care system and costs involved. As mentioned above, a free health service raises concern about the quality of the service. The participants also considered the service delivered by private doctors as of a higher quality than the public health care service. This finding is supported by existing views of the quality of health care service in relation to the divide between those that can afford private health care and those that need to seek public health care as it is more affordable, also the impetus of the National Health Insurance in South Africa (Bulletin of the WHO, 2010). When considering the different levels of work satisfaction among professional nurses in the public and private sector (Pillay, 2009), it is likely that the lower level of satisfaction among nurses in the public sector negatively impact their client services including interpersonal relationships whereas those working in the private health care sector showed higher levels of satisfaction and therefore more likely to translate this into more positive outcomes for their clients (Pillay, 2009). The view was also expressed that health care delivery was better in their home country. It is however difficult to assess as health systems research is absent from the DRC and the little information that is available suggests that various problems are being experienced in health care delivering including immunisation coverage (Mapatano et al., 2008).

The overall dissatisfaction with public health care delivery is concerning as this seems to be a continuing problem. This corroborates with earlier research findings that reported negative attitudes of health care workers and discrimination against them based on them being foreign nationals (Apalata et al., 2007; Crush &Tawodzera, 2014; Zinhindula& Meyer-

Weitz, 2015). The results pertaining to the consultation encounter at the public health care clinic were also very negative as most felt that they were not able to ask the questions they wanted, that they were not provided with the necessary information nor felt that enough time was spent with them during the consultation process and lastly that they had to wait too long to be assisted at the clinic. The language barrier in the public health care clinics was likely to have contributed to some of the dissatisfaction the care givers experienced. No significant differences were however detected among those with no and some level of English language proficiency. In contrast to the clinic, the caregivers felt more satisfied with the services rendered by the private doctors. It should be noted that about half of these doctors consulted were Congolese and therefore able to consult in French, likely to have contributed to effective communication and therefore greater satisfaction with the service as suggested by Morales et al. (1999).However, those care givers that reported higher levels of English proficiency reported slightly higher levels of satisfaction with the services implying that better communication with non-French speaking occurred and therefore higher levels of satisfaction with the service rendered. These differences were however not statistically significant. Waiting times as discussed earlier and inadequate time spent during consultation with the health worker, were also aspects that negatively influenced their experiences of the consultation process. In the article "A day in the life of a clinic queue" by The South African Health News Service (3 September, 2014) reported an average waiting time at clinics to be about 5 hours and clients also raised negative attitudes towards clients seeking health care treatment. In the study of Masango-Makgobela, Govender and Ndimande (2013) complains for not returning to a particular clinic include long queues and long waiting time, rudeness of clinic staff and a lack of medication. Therefore the caregivers' dissatisfaction with the public health clinic services to their children seems to be aligned to issues raised by other South African clients about health care service delivery in general. With regards to

caregivers' perceptions about xenophobia it is also possible that in a context where widespread xenophobia exists (Crush, 2009; Crush & Ramachandran, 2010), the negative attitudes and rude behaviours of nurses as reported by Masango-Makgobela et al. (2013) could be interpreted by the caregivers as medical xenophobia. In light of limited research insight into health providers' views about health care delivery to migrants and refugees a deeper understanding of medical xenophobia is not possible and studies among health workers is therefore important to enhance the quality of health care delivery to foreign nationals in South Africa.

Contrary to expectation, no significant individual demographic group differences (gender, level of education and English proficiency) as well as household resources apart from social networks were found among the caregivers with regards to their satisfaction with child health care services in general and in relation to the consultation process pertaining to their children. The care givers with higher number of social networks seemed significantly more satisfied with public health care delivery and the health care services by private doctors. It is likely that social networks assist caregivers in identifying possible interpreters to assist them when seeking assistance at the public health facilities and also assist caregivers in seeking health care from particular Congolese doctors, who is likely to improve the consultation experience because of more effective communication as outlined above.

The lack of diverse views about the public health care service could also be a consequence of the strong cohesion and seemingly closed networks among members of the DRC refugee community further enhanced by generalised xenophobia in the South African society. The negative side to social capital therefore results from excessive social cohesion in groups e.g. families, language and ethnic groups that impact various aspects of society including

economic opportunities (Portes, 2014; Portes & Sensenbrenner, 1993; Waldinger, 1995) as well as "group think" leading to judgement errors as trust in the group's views inhibits independent thinking (Janis, 1997). Therefore sharing negative experiences with public health care services are likely to be internalised as their own negative experiences.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

In this chapter the final conclusions in relation to the research results and discussion will be presented followed by some limitations of the study and recommendation stemming from the results.

6.2 Conclusions

Refugees face various challenges ranging from socio-economic conditions to limited access to health care services that are all likely to impact negatively on their health and wellbeing. The low socio-economic status and daily struggles for survival is a concern, especially as some refugees have untapped skills and abilities that could be utilised to better support themselves but also contribute to the South African economy. Basic survival seems possible as a result of the supportive refugee community where social networks are used for financial, information and emotional support.

As refugees are considered to be vulnerable groups because of the experiences of armed conflict, the lack of physical and mental health screening can be viewed to result in missed opportunities for interventions i.e. care, support and treatment. It was however remarkable that all children's early childhood immunisation was up to date despite the problems with immunisation coverage in the DRC. This shows the commitment or parents and caregivers to children's health issues. However, the slight delay in health care seeking, longer than four days for children that are ill, is likely a consequence of limited resources and negative

experiences with health care services. This is a cause of concern as this delay may have serious health impacts on a young child.

The geographical accessibility of the public health care clinics improves access to the refugees who do not have adequate financial resources to travel to health care facilities. The services of private doctors primarily Congolese, are also sought in cases where children are not getting better or when illness is considered to be serious.

The availability of public health care services are constrained by the long waiting hours for services and the fact that caregivers, due to their other household responsibility are not always able to wait a full day before receiving health care for their children. In addition, language as a barrier seem to play a role in service delivery and the need for interpreters by caregivers when seeking health care may be an additional constraint, especially as the person also have to wait for many hours.

The caregivers reported to be highly dissatisfied with the health care services for their children, particularly the health service delivery in public health care facilities. Apart from the long waiting hours, the negative attitudes and discriminatory behaviours by health care workers contribute to caregivers' views about the poor quality of the health care service. While this finding corroborates with other research findings, a lack of studies among health workers in public health care facilities and the challenges in delivering health care to refugee populations will be necessary to better understand health care service delivery to refugees.

This study seemed to be the first conducted among parents/caregivers of refugees in Durban pertaining to child health care services and therefore fills a gap in existing knowledge in this regard. Improving access to quality child health care is a moral responsibility of all

governments, as accessible and quality health care service delivery at a young age will not only contribute to a reduction in preventable child deaths, but will also improve health and wellbeing outcomes in later years.

6.3 Limitations of the study

While the explanatory mixed method approach attempted to improve the quality of the findings, some limitations should be noted and care should be taken in understanding of the results.

The study was only conducted in one refugee community i.e. refugees from the DRC living in Durban. The community's experiences with child health care service delivery might be different for other refugee groups in Durban and those living in other parts of South Africa. Care should therefore be taken in generalising the findings to other refugee caregivers. In addition, the relatively small sample size and the use of non-probability to select respondents in the quantitative study restrict generalisation to all DRC refugee caregivers.

The understanding of health care delivery to children from parents or caregivers' perspective provides only a one dimensional perspective of service delivery as the view of health care workers is absent. Their views might have contributed to a better insight into service delivery challenges faced by health care workers within the constraints of current public health care delivery. It should be noted that some attempts were initially made to include health workers in the study, but permission to conduct such a study could not be obtained.

6.4 Recommendations

In light of the challenges identified in the study among caregivers in accessing health care for their children, recommendations related to refugees and the health system are as follow:

Refugees:

- Refugees should be made aware of the South African health care system and policies that govern health care delivery to ensure a better understanding of the system and the need for foreign nationals to present with documentation to receive health care. This will also ensure a realistic expectation and prevent unnecessary disappointment with the system.

- It would be important for refugees to have a better knowledge of organisation offering services to refugee this will also assist in a better understanding of the supportive role that they play.

- Efforts to identify the skills set of refugees and then link them to industry could be a way in which to utilise untapped skills for the South African society.

- Refugee community organisations and networks could play a useful role in delivering health information and promotion among the refugee community.

Health care system:

- Physical and mental health screening for refugees should be mandatory to identify support and treatment required for individuals but also contain communicable diseases. This is especially so for HIV testing to prevent MTCT.

- Within the South African context where xenophobic attacks on foreign nationals, likely to also suffer from trauma related to armed conflict in their countries of origin, the mental health of refugees cannot be overlooked and outreach activities are required by mental health professionals to address the mental health needs of caregivers and children.

- Health workers should be made aware of the Rights of refugees and asylum seekers (also the Refugees Act), ethical practice in relation to the South African Constitution and Bhato Pele principles to deliver better services to the public by government employees.

- Training and support to assist health workers to better prepare them for the likely challenges they may face in health care delivery to foreign nationals to improve client perceptions and service delivery.

- Consideration should be given to the use of translators/interpreters at public health care facilities used by refugees to improve health care delivery. For example, individuals from the refugee community with a background in health could be trained and employed to assist in translation and interpretation in health care contexts.

- The establishment of early day care centres for financially constrained communities within urban areas would not only enable parents and caregiver the opportunity to participate in economic activities but will also assist in greater integration of refugees into the South African society that is likely to impact positively on the health and wellbeing of refugees.

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APPENDIX 1: ETHICAL CLEARNCE TO CONDUCT THE STUDY

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

11 March 2013

Mr James B Lukobeka (212519915)
Applied Human Sciences
Howard College Campus

Protocol reference number: HSS/0123/013M
Project title: Health care service delivery to refugee children from the Demographic Republic of Congo living in Durban, South Africa: A care giver's perspective

Dear Mr Lukobeka

Expedited Approval

I wish to inform you that your application has been granted Full Approval through an expedited review process:

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....

Professor Steven Collings (Chair)
/ms

cc Supervisor: Prof Anna Meyer-Weitz
cc Academic Leader: Professor D McCracken
cc School Admin: Ms Nondumiso Khanyile

Professor S Collings (Chair)
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APPENDIX 2: CONSENT FORM FOR INDIVIDUAL PARTICPANTS (CAREGVIVERS)

An investigation on accessibility to health services for refugees' children from the Democratic Republic of Cong living in Durban

Dear participant;

I am Bukenge Lukobeka James; student at the University of Kwazulu-Natal Durban. As a requirement of my studies it is necessary that I research in Community Health in order to complete my degree in the School of Human Applied Sciences, Discipline of Psychology.

I am requesting your cooperation in this research with the main objective to investigate the challenges facing by refugees caregivers of children regarding access to health care services and to explore the quality of health care provided to refugee children in the local clinic in Durban. In this research you are required to inform us about all your experiences when you trying to access health care services. I am going to give you this questionnaire than you will complete with my assistance.

You are not forced to take part in this research and you can withdraw from participation at any time.
Your name will be anonymous and the information that you will give will not be publishing but will be kept in confidence between me and my supervisor.

Should you have any further questions you may call me in the School of Applied Human Sciences, Discipline Psychology at the University of KwaZulu-Natal on +27 (0) 31 2607618. If you have any questions about your rights as a participant please contact Phumelele Ximba in the research office at the University of KwaZulu-Natal on +27 (0) 31-2603587 or email: **ximbap@ukzn.ac.za**.

Thank you for your participation

BJ Lukobeka

PARTICIPANT'S DECLARATION

I ……..... (Full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project as discussed with me based on the previous page of this document, and I give consent to participate in the study. I also grant permission for interviews to be audio taped, and for the transcribed interview material to be utilized for research purposes only. I fully understand that all the information that I provide will be kept confidential and anonymous.

I understand that my participation is voluntary and that I am at liberty to withdraw from the study at any time, should I so wish.

_____ _____

Signature of participant Date

_____ _____

Signature of researcher Date

APPENDIX 3: QUALITATIVE INTERVIEW SCHEDULE FOR CAREGVIVERS

SECTION A: DEMOGRAPHIC DATA

1. **Parent/Caregiver's Age: …….**
2. **Gender:**
   1. Male 2. Female
3. **Marital Status please ticks one:**
   1. Married; 2. Living Together 3.Single, 4. Separated; 5. Divorced; 6. Widowed

4. Age of Child:

Child1 …… Child2….. Child3……. Child4……. Child5…….. Child6…… Child7….. Child8……. Child9…….

4. Level of Education ……..

MEDICAL HISTORY QUESTIONNAIRE

1.What kind of previous illnesses did your children experience and what actions did you take?
Also Probe:
What do you do when your child falls ill?

2. Where do you normally go to when your child needs medical care?
Probe: reasons for choosing the preferred clinic? Private or Public.
Probe: What are the reasons for preferring the clinic, hospital or private doctor?
Probe: Whether the care giver was influenced by advice from family/friends/ other refugees?

3. On an average, how long do you normally wait before you take your sick child to the clinic or the hospital?
Probe: If more than 4 days - ask - What are the main reasons why you wait first.

4. How did the health care workers made you feel when you visited the clinics?

Probe: Whether you were scared because of what others said about them?

Probe: Feelings of anger even before going to the clinic/hospital?

Profbe:

If not treated well: Ask did they say anything or do anything that made you feel that they did not treat you well? Did they ask you questions about your child? Did they take the child's temperature? How? What were they saying? Why did you feel humiliated?

5. Were you satisfied with the health care service that you received for your child at the clinic? [Probe: Reasons for answer]

6. How did your child respond to the treatment received from the clinic?

7. Have ever used the services of a private doctor?

How would you describe the differences between the services you received?

8. Do you feel happy to go to local clinic? [Probe: please explain more]

9. How would you describe the healthcare service at the public clinic?

10. Have you ever faced a language problem at the clinic? Explain.

11. What kind of health care problems do you share with your friends?

12. Would you refer you friend to one of these clinics you often visit? Reason?

APPENDIX 4: QUANTITATIVE RESEARCH QUESTIONNAIRE

SECTION A: DEMOGRAPIC INFORMATION

Q1.Parent/Caregiver's Age: ……

Q2. Gender:
Male 2. Female

Q3.Marital Status:
1.Single, 2. Separated, 3. Living Together; 4. Married; 5. Divorced; 6. Widowed
7. Other …….

Q4.Care giver relationship with Child (ren).
1. Mother; 2. Brother; 3. Uncle'; 4. Father; 5. Aunty; 6. Other ……

How many children do you have of your own and how old are they?

Child	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Gender								
Age								

How many other children are responsible for and how old are they?

Child	Child 1	Child 2	Child 3	Child 4	Child 5	Child 6	Child 7	Child 8
Gender								
Age								

Q5.What is your highest level of education? ……

Q6.To which religious group do you belong?.....
Christian (Protestant & Catholic); Muslim; Other specify
……
Q7. Language: Can you understand, speak and write in English?
……
I can write only
Yes I can Write and Speak
I can only understand 4.
No I can't understand, speak or write in English

Q8. SES
I am going to read a number of statements to you. Which one best describes your household situation? (M*ark only one*)

1	Not enough money for basic things like food, clothes	1
2	Have money for food and clothes but short on many other things	2
3	We have the basics but not enough money for expensive items	3
4	Have money to save or buy expensive things	4
5	Other (specify) ……..	5

SECTION B. BACKGROUND

Q1. Do you have any legal documentation allowing you to stay in South Africa?
Yes 2. No

Q2. If Yes: Please tick what you have

Permit for asylum seekers,
Refugee's Status
ID Book (South African Green ID)
Others specify …….

Q3. Managing in South Africa

How do you survive in South Africa? …….	Yes	No
Q3.1. Work full time in a job	1	0
Q3.2. Do part time work whenever I can	1	0
Q3.3.Get help from family/friends in South Africa	1	0
Q3.4. Get help from the church/pastor	1	0
Q3.5.Get money from family/friends in the DRC	1	0
Q3.6. Sell some of my things to get money	1	0
Q3.7. Use my skills to get some money/food	1	0
Q3.8. Buy and sell goods	1	0
Q3.9. Do you think that you have knowledge and skills that is not used in South Africa? Explain: ……	1	0
Tell me about your social networks …….		
Q3.10. Do you know people that can help you when you need help?	1	0
Q3.11. Do you know people who know others that can help you?	1	0
Q3.12. Are the people you know willing to help you?	1	0

Q4. **If you're not working why do you think you are not employed?**

……..
1=Discrimination; 2= No Job
3= I'm not able to work; 4= Many people in Durban is unemployed
5= Unable to speak English 6=Others

Q4.1. If you're not working: Are you looking for a job?
1. Yes 2. No

Q5.**How many people are you supporting in your house?**

……
1=1-3; 2=3-6
3=More than 6;

Q6. With how many people are you sharing your accommodation?

……
1=1-2; 2=3-5; 3=More than 6

Q7. How would you describe your living conditions?

……
……

SECTION C. SOCIAL NETWORKS

Q1. Why did you choose to come to Durban and not any other town or province in South Africa?

……...
I don't kwow
Because of my relatives living her contacted me
Because I came for Mozambique and I didn't know if there is others provinces in SA
Because of jobs opportunities
Other ……..

Q2. Did you know any person in South Africa before coming here?

Yes; 1 No 2

Q3. Did they know that you were coming to South Africa?
Yes; 2=No

Q4. Did they make you feel welcome when you arrived in South Africa?
Yes; 2=No

Q5. How often do you meet with them?
1=Every Day 2=Every Sunday After church
3=Once a Month 4=If we have Ceremonies in our Community
5=we don't meet 6=Once a Year
7=Others (Specify

Q6. What was the biggest challenge you faced when arriving in Durban?
……
1.Accommodation 2.Food 3.Other ……

Q7. What are the challenges you face now?
……
1=House 2=Health issues
3=No Job 4=Lack of school fees for their children
5=Lack of food 6=Transport
7=Others (specify)

Q8. Have you ever visited the United Nations high commissioner for refugees' (UNHCR) offices?
1=Yes 2=No

Q9. If Yes: For what reason(s)?

…….

1=For Social support 2=For my refugees' documentation problems
3=Just for a visit 4=For relocation
5=for health care issues assistance 6=others (specify)

Q10. Have you ever visited the offices of NGOs working with refugee people from other countries?

1=Yes 2=No

Q11. If Yes Please note the kind of assistance and Name of NGO:

……

Q12. Are you belonging to any political, cultural or religious organization?

Yes 2. No

Q13. Have you ever receive any assistance from your community?

Yes 2. No

Q14. Have you ever given any assistance to any other refugee(s)?

Yes 2. No

Q15. If Yes: What kind of assistance did you give?

…….....

Q16. Should you ever have financial problems, who do you think will assist you?

1. Friends from my country 2.Colleagues from work
3. Relatives or organizations 4. Church communities
5. Other: Specify, ……

Q17. What can be done to solve this problem of accessing health care services by refugees?

To engage interpreters in public hospitals to overcome the language problems
To engage or abroad Congolese nurse or other Francophone nurses from others countries in the public hospitals
To awareness among South African nurses to respect medical ethics and respect for refugees rights
I don't know, (Nothing)
To use all those mechanism: 1,2 &3
Others (specify)

SECTION D. MEDICAL HISTORY QUESTIONNAIRE

Q1. **When you arrived in South Africa did you and your family received a complete health assessment?**

Medical Assessment	Yes	No
Q1.1. Physical medical check-up?	1	2
Q1.2. Mental health assessment?	1	2

Q2. Have your children been immunised?
1.Yes 2. No

Q3. Place of immunisation:
1. In South Africa 2. In DRC, 3. Other …….

Q4. If Yes: For what have they been immunized? (Ask to see Immunisation Card or any documentation)

Disease	Yes	No
BCG	1	2
Polio	1	2
Measles	1	2
OPV	1	2
All	1	2
Other …….	1	2

Q5. What is your understanding of immunisation?

I don't know/ I forget	1
Immunization protects children against diseases	2
To cure diseases	3
To improve children's health	

Q5.1. Have all your children completed their immunisation?
1. Yes; 2. No

Q6. Have any one of your children been ill lately?
1.Yes 2. No

Q6.1. If Yes: What did you do?
Asked my friend/neighbour for help
I went to the local clinic
I prayed to God
I bought medicine from the Pharmacy

Q7. Once your child is ill, for how long do you normally wait before taking him/her to the clinic or doctor?
…….

Q7.1. If longer than 4 days: What are the reasons for waiting this long?

……..

1. Because of the Distance to the clinic
2. Because I don't have transport money
3. Because they can't help my child clinic
4. Because they don't like refugees in the
5. Because I don't have valid documents
6. Others

Q8. Where do you normally go when your child needs medical care?

1. Public clinic
2. Hospital
3. Private Doctor
4. Local herbalist
5. Local traditional healer

Q8.1. If Public Clinic: Why did you choose to go to the clinic?

……

1. Because the services are free
2. Because of the good quality of services
3. Because I like it
4. Because is not far from my place
5. Because I don't have money to go to the private doctor

Q8.3. If Private Doctor: Where is the doctor from?

…….

Congolese	1
From another African country?	2
SA - Indian?	3
SA - White?	4

Q8.4 If you visited a private doctor – What were your reasons for doing so?

……

1. Because the services are free
2. Because of the good quality of services
3. Because is close to my home.

Q9. Where did you learn about the services offered by the clinic?

…….

1. Because I have been there once
2. From my community
3. From my friends
4. From my church
5. In the street

Q10. How did you get to the clinic?

1. By taxi
2. Own car
3. Walking
4. Other specify

Q10.1. If used transport: How much did the transport cost you to go to the clinic?

1. R 10
2. R 20
3. < R20
4. Other

Q11. Share some of your experiences at the clinic.

……..

Q12. If you were unhappy why?

…….

1= I don't know 2= To spend all day there without getting any help
3= For Being victim of insult at the clinic as a refugee
4= Others (specify) ……

Q13. Did your child get better?

1=Yes; 2=No

If No: What did you do? ……

1=Nothing (just stay with him at home) 2=I prayed to God at home
3=I changed clinic 4=Bought medicine from the pharmacy
5=I went to the traditional doctors 6=I went to the private doctor/hospital
7=Others (specify)

Q14. Do you feel that you can be open and honest at the local clinic?

1.Yes 2. No

Q15. Where do you get information from about health issues?

	Yes	No
From my friends	1	0
From the nurse at the clinic	1	0
From the private doctor	1	0
From my neighbours	1	0
From the people at church	1	0
Media	1	0

Q16. Have you ever lost a child?

1.Yes; 2. No

Q16.1. If Yes what was the cause of death?

Illness
Accident
Other Specify:

SECTION E: SATISFACTION WITH HEALTH CARE SERVICES

When you think back over the last 6 months: How would you rate your satisfaction with the health services you child/children younger 10 years and younger received? Use a scale from 0 to 10 (0 not satisfied at all and 10 highly satisfied) to indicate your satisfaction.

1. The private doctor(s): (Not applicable – did not seek the help of a private doctor)

0	1	2	3	4	5	6	7	8	9	10

2. The local clinic: (Not applicable – did not seek the help of the local clinic)

0	1	2	3	4	5	6	7	8	9	10

3. A faith healer: (Not applicable – did not seek the help of a faith healer)

0	1	2	3	4	5	6	7	8	9	10

4. The local herbalist (Not applicable – did not seek the help of a herbalist)

0	1	2	3	4	5	6	7	8	9	10

5. The traditional healer (Not applicable – did not seek the help of a traditional healer)

0	1	2	3	4	5	6	7	8	9	10

6. Satisfaction with clinic and private doctor

A. Local clinic		
The last time your children/child was taken to the clinic …….	Yes	No
1.Were you able to ask all the questions you wanted to ask?	1	0
2.Did the nurse provide you with enough information?	1	0
3.Do you feel that the nurse spent enough time with you?	1	0
4.Will you recommend the services of this clinic to others? What would you say?	1	0
5.Did you feel that you had to wait too long before being helped? Why do you say this? ……	1	0
6.Did you feel that the nurse respected your opinions about your child's health care needs? Why:…….	1	0

B. Private Doctor		
The last time your children/child was taken to the private doctor …	Yes	No
1.Were you able to ask all the questions you wanted to ask?	1	0
2.Did the doctor provide you with enough information?	1	0
3.Did you feel that the doctor spend enough time with you?	1	0
4. Will you recommend the services of this doctor to others? What would you say: ……	1	0
5.Did you feel that you had to wait too long before being helped? Why do you say this? …….		
6.Did you feel that the doctor respected your opinions about your child's health care needs? ; Why:	1	0
7. How would you compare the Health care you received in your country to the health care in South Africa? ……..…….....		